THE INFLUENCE OF CULTURAL BELIEFS ON SOCIAL WORK INTERVENTION IN MENTAL HEALTH: VIEWS OF FRONTLINE SOCIAL WORKERS

by

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DECLARATION

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SUMMARY

Despite the known influence culture has on the lives of all individuals, social work and many other disciplines, no other variable is so poorly informed and untested as culture. There is also a need to shift research to focus on intervention and include evaluations of evidence-based cultural appropriate methods of assisting individuals. In turn, this study aimed to investigate the influence of cultural beliefs on social work intervention in mental health. A clear focus was placed on mental health due to the acknowledgment of mental health being a significant public health issue in South Africa. A qualitative research approach was used for this study. This assisted in attaining in-depth accounts of the participants' views. Both descriptive and exploratory research designs were utilised for this study. These designs further substantiated the need for attaining varying narratives from the participants. Furthermore, a purposive sampling method was used under which a criterion for inclusion was established.

Fifteen participants were interviewed, using a semi-structured interview schedule, attached as Annexure B. Following this, the attained data was transcribed and thereafter analysed using thematic analysis. Based on these results, the main conclusions drawn from the findings included that social workers may not have a clear understanding of culture. Also, the caseloads of social workers negatively impact their intervention and therewith their ability to acknowledge culture and cultural beliefs in social work intervention. This is of great concern in the context of South Africa where approximately 30 cultural groups exist and where mental health statistics are rife. In light of the aforementioned, it is recommended that tertiary educational institutions include culture and its components (like cultural beliefs) more extensively into the curricula thus including in a student's practice education. Moreover, The South African Council for Social Service Professions (SACSSP) and the National Department of Social Development should address the workload and working conditions of all social workers. This may assist social workers in developing their ability to acknowledge culture and cultural beliefs in social work intervention.

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OPSOMMING

Ondanks die bekende invloed wat kultuur op die lewens van alle individue, maatskaplike werk en vele ander dissiplines het, is geen ander veranderlike so swak ingelig en ongetoets as kultuur nie. Daar is ook 'n behoefte om navorsing te verskuif na fokus op intervensie en evaluering van bewys gebaseerde kulturele geskikte metodes. Hierdie studie was daarop gemik om die invloed van kulturele oortuigings op maatskaplike intervensie in geestesgesondheid te ondersoek. ‘n Duidelike fokus is op geestesgesondheid geplaas omdat geestesgesondheid 'n belangrike openbare gesondheidskwessies in Suid-Afrika is. ‘n Kwalitatiewe navorsing benadering is vir hierdie studie gebruik. Dit het die navorser gehelp om 'n diepgaande weergawe van die deelnemer se standpunte te kry. Beide beskrywende en verkennende navorsingsontwerp is vir hierdie studie gebruik. Hierdie ontwerpe het verskillende verhale van die deelnemers gekry. Verder is 'n doelgerigte steekproefmetode gebruik waarvolgens 'n kriterium vir insluiting vasgestel is.

Vyftien deelnemers is ondervra, met behulp van 'n semi-gestruktureerde onderhoud skedule, aangeheg as aanhangsel B. Hierna is die data getranskribeer en daarna geanaliseer met behulp van tematiese analise. Op grond van hierdie resultate het die belangrikste gevolgtrekkings uit die bevindinge ingesluit dat maatskaplike werkers moontlik nie 'n duidelike begrip van kultuur het nie. Verder beïnvloed die saak lading van maatskaplike werkers hul intervensie en daarmee hul vermoë om kultuur en kulturele oortuigings in maatskaplike werk intervensie te erken. Dit is baie kommerwekkend in Suid-Afrika waar ongeveer 30 kultuurgroepe bestaan en statistieke oor geestesgesondheid voorkom. In die lig van die bogenoemde word dit aanbeveel dat tersiêre opvoedings instellings kultuur en die komponente daarvan (soos kulturele oortuigings) meer omvattend in die kurrikula insluit, en dus in die praktyk opleiding van 'n student insluit. Boonop behoort die Suid -Afrikaanse Raad vir Maatskaplike Diensberoepe (SACSSP) en die Nasionale Departement van Maatskaplike Ontwikkeling die werklading en werksomstandighede van alle maatskaplike werkers aan te spreek. Dit kan maatskaplike werkers help om hul vermoë om kultuur en kulturele oortuigings in maatskaplike werk -intervensie te erken.

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CHAPTER ONE:

INTRODUCTION OF THE STUDY

1.1. INTRODUCTION AND RATIONALE

Culture and the influence it has on the lives of individuals is significant. Barrera, Vastro, Strycker and Toolbert (2017) align with the aforementioned and confirm that culture is shared unconsciously by a group of people, who use it to guide their daily living. Culture is defined as a set of interrelated behaviours, beliefs, values, attitudes, and practices that is transmitted or communicated from generation to generation (Sheafor & Horesji, 2006). A component of culture and also the focus for this study, cultural beliefs, is defined as awareness or understanding of one's culture and that of others (Wolf, Wu, Spadaro & Hunker, 2020). Cultural beliefs determine how individuals perceive, think, and feel (Spencer-Oatey, 2012). It assists individuals to make sense of their world and to find meaning in and for their lives (Singer, Dressler, George & The NIH Expert Panel., 2016). When applied to mental health, cultural beliefs influence how mental health is viewed, addressed, and managed by individuals (Jimenez, Bartels, Cardenas, Dhaliwal & Alegria, 2012).

According to the World Health Organisation (WHO), mental health is a "state of well-being in which an individual realizes his or her abilities, can cope with the normal stresses of life, can work productively, and can make a contribution to his or her community" (World Health Organization, 2018:1). Globally, ill mental health diagnoses contribute approximately 14% of the global burden of disease, with research indicating that between 25% and 50% of adults, worldwide, will struggle with a mental health diagnosis (Burns, 2011; Patel, Woodward, Feigin & Heggenhougen, 2010). In South Africa mental health diagnoses rank third in their contribution to the burden of disease (Meyer, Matlala & Chigome, 2019). One in every six South Africans struggle with mental health and only 27% of the population who is diagnosed with severe mental health, receive treatment (South African College of Applied Psychiatry, 2018). This highlights mental health as a significant public health issue worldwide and in South Africa.

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Approximately 30 different cultural groups coexist in the South African population (Statistics, South Africa, 2019). This further contributes to the complexity of public mental health issues in the country. Cultural beliefs play a powerful role in shaping an individual's understanding of mental health. Acknowledging the role of cultural beliefs in mental health is accepting that people have their own ways of describing symptoms, seeking, and receiving intervention. Mental health and therewith intervention, in the context of South Africa, requires a broad range of services that acknowledges individual and cultural characteristics as well as the multiple mechanisms that influence ill mental health (Stein, 2014).

The Mental Health Care Act No. 17 of 2002 supports mental health care intervention that upholds the human rights of all individuals, thus acknowledging an individual's right to practice the culture of their choice (Bill of Rights, Chapter Two of The Constitution of the Republic of South Africa, 1996). It also identifies social workers, alongside others, as mental health care practitioners. Multiple methods of social work intervention are considered appropriate in mental health. Service provisions span across rehabilitative, protective, preventative, and developmental goals (Patel & Hochfeld, 2013). In South Africa, social workers are employed in healthcare settings through government, non-profit organisations, and private sectors (Zimba, 2020). Social workers, delivering intervention in mental health, comprehensively assess the patient's life situation and source solutions to support the individual and their family at the right times during the care process (Yliruka, Heinonen, Satka, Metteri, Alatalo; 2020). Social workers thus offer emotional support and provide information about the mental health diagnosis, the potential changes to the individual's life situations, and how the individual can strengthen their overall well-being (Yliiruka, et al., 2020).

Rankopo and Osei-Hwedie (2011) describe the social work profession as moulded to suit and assist individuals belonging to varying cultural groups. This is complemented by the Global Definition of Social Work, which states that social work is a practice-based profession and an academic discipline that promotes social change and development, social cohesion, and the empowerment and liberation of people. Principles of social justice, human rights, collective responsibility, and respect for

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diversities are central to social work. Underpinned by theories of social work, social sciences, humanities, and indigenous knowledge, social work engages people and structures to address life challenges and enhance wellbeing (International Federation of Social Work and International Association of Schools of Social Work, 2014). Aligning with the views of Rankopo and Osei-Hwedie (2011), The Global Definition of Social Work, confirms a social worker's professional and conscious ability to interact with individuals who belong to varying cultural groups. It also emphasises that the social work profession aims to enhance an individual's well-being, thus including their mental health.

This study aimed at gaining an understanding on how mental health is conceptualized in varying cultural groups and how the content of social work intervention is influenced when interacting with individuals who struggle with their mental health and uphold varying cultural beliefs. Extending this study from the view of social workers is imperative to this study. The social work profession is cognisant of culture and well-versed in enhancing the well-being of all individuals (International Federation of Social Work and International Association of Schools of Social Work, 2014). With this in mind, social workers are well-suited to provide narratives on the influence of cultural beliefs on social work intervention in mental health. This study is specific to the context of South Africa as its mental health statistics paint a concerning picture for its population (Pillay, 2019). By investigating the influence of cultural beliefs on social work intervention in mental health, this study aimed to strengthen mental health intervention in the country and therewith respect the diversity of the South African population.

1.2. PROBLEM STATEMENT

Intervention offered by social work professionals as described by The Global Definition of Social Work, is guided by principles of social justice, human rights, collective responsibility, and respect for diversities (International Federation of Social Work and International Association of Schools of Social Work, 2014). In respecting diversities, social workers acknowledge culture as an essential process of well-being and therewith an individual's survival (Ogundare 2020). Considering an individual's cultural context and their environment when delivering intervention, means that social workers acknowledge how people react to social problems, how they prefer to be treated, and

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the expectations created by their culture (Lotfi, 2019). Cultural beliefs define the norms for mental health and when acknowledged in social work intervention, it promotes the inclusion of local systems of knowledge, concepts, rules, and practices for intervention in mental health (Schiller & De Wet, 2019). Despite the great influence culture has on the lives of individuals and social work intervention, no other variable in research is so poorly informed and untested as culture (Singer, Dressler, George & The NIH Panel, 2016). Lund, Petersen, Kleintjes & Bhana (2012), align with the aforementioned and identifies an urgent need to shift research to focus on intervention and include evaluations of evidence-based culturally appropriate methods of assisting individuals.

In the South African context, the need to deliver culturally appropriate services is extensive (Ugiabe, 2015). The ability to co-exist, experience culture, and express cultural beliefs was not always the milieu for the South African population. This, in turn, promoted a system where the vast diversities of the local people were dismissed and created several further risk factors for mental health (Abdullah, 2015). Pillay (2019) confirms the aforementioned and describes the statistics for ill mental health as rife, and a significant public health issue for those residing in South Africa. This study aimed to fulfil the aforementioned research gap. Thus, it aimed to research culture and also focus on intervention and include an evaluation of culturally appropriate methods of delivering social work intervention in mental health. In turn, it further aimed to respond to the mental health needs present in the context of South Africa. Using search engines such as Google Scholar, Science Direct, Academia.edu, Elsevier and Taylor and Francis Online, the study aimed to investigate the influence of cultural beliefs on social work intervention in mental health. This study aimed to give recognition to cultural beliefs, respect, and acknowledge the diversity of the multicultural South African population and therewith strengthen social work intervention in mental health.

1.3. RESEARCH QUESTION

The above discussion gave rise to the following research question:

- What are the views of frontline social workers regarding the influence of cultural beliefs on social work intervention in mental health?

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1.4. GOALS AND OBJECTIVES

The goal of this research study was to gain an understanding of the influence of cultural beliefs on social work intervention in mental health.

To achieve this goal and effectively explore the above question, the following objectives were formulated:

- To provide an overview of culture and conceptualize cultural beliefs and its influence on social work intervention.
- To provide a critical analysis of the influence of cultural beliefs on social work intervention in mental health using Kleinman's explanatory model.
- To empirically investigate the views of frontline social workers regarding the influence of cultural beliefs on social work intervention in mental health.
- To present conclusions and make recommendations on the influence of cultural beliefs on social work intervention in mental health to frontline social workers who are working in the field of mental health.

1.5. THEORETICAL POINTS OF DEPARTURE

The theoretical point of departure for this study is Kleinman's Explanatory Model. The explanatory model, when used in the intervention, can explain five interrelated issues of the problem a client is facing. These include the aetiology of the illness or presented need or social problem, the timing, and mode of onset of symptoms, pathophysiology, the course or timeline of the problem, and the appropriate treatment (Buus, Johannessen & Stage, 2012; Kleinman, 1980a; Petkari, 2015). When applied to intervention, the explanatory model involves asking questions in an explanatory way, similar to the way one would conduct a qualitative research approach (Awan, Jahangir & Farooq, 2015). The data gathered by this process would include multiple and complicated responses which consist of descriptions about the problem, culture, communication systems, and other forms of knowledge (Awan, Jahangir, & Farooq, 2015). This is useful when planning for intervention as individuals may have experience or know what works for them, the resources available to them, and what the culture prescribes for intervention (Lotfi, 2019). The explanatory model, like cultural beliefs, is not static, rather it is dynamic and flexible. The outcomes of implementing Kleinman's explanatory model in intervention will differ greatly from culture to culture and at times, even within a culture (Awan, Zahoor, Irfan, Naeem,

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Nazar, Farooq, & Jahangir, 2015). By acknowledging the aforementioned, it can be stated that an individual's explanatory model is greatly subjective and particularly in accordance with their cultural beliefs. This is largely because cultural beliefs assist individuals to make sense of their world and to find meaning in and for their lives (Singer, Dressler, George & The NIH Expert Panel., 2016). Cultural beliefs are interrelated to Kleinman's Explanatory Model and for this reason, it was a well suited theoretical point of departure for this study. Extending intervention from Kleinman's Explanatory Model calls for multiple ways of understanding mental health and this is imperative to social work intervention, delivered in the South African context where approximately 30 different cultural groups coexist (Statistics, South Africa, 2019)

Social workers in South Africa deliver intervention in multifaceted situations with unique individuals from multicultural backgrounds (Schiller & De Wet, 2019). Despite the best efforts of social work professionals, social work intervention, particularly in the South African context, has been criticized for employing Western knowledge models originating from America, Australia, and Britain, and failing to acknowledge the ideologies of the local people of the country (Schiller & De Wet, 2019). As a result, there is a need for social work intervention to redress western knowledge models in intervention and shift towards the view and practices of those who reside and experience life in the South African context. Using the explanatory model to guide social work intervention, particularly in the field of mental health, is an example of how this need can be addressed. Social work intervention, using the explanatory model as a point of departure, will allow the social worker to become more acquainted with the knowledge of the local individuals and therewith their cultural beliefs. (Shokane & Masoga, 2018).

1.6. CONCEPTS AND DEFINITIONS

The description of the following concepts is necessary for promoting the conceptualization of this study.

1.6.1. Cultural Beliefs

Every culture is characterized and distinguished from other cultures by deep-rooted and widely acknowledged ideas about how people should feel, think and act as well-

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functioning members. Cultural beliefs are identified as the ideas, knowledge, values, goals, and attitudes of individuals, as guided by their culture (Bornstein, 2013).

1.6.2. Social Work Intervention

Intervention is described as the scientifically established processes and patterns practitioners apply to cases of individuals, groups, and communities (Ebue, Uche & Agha, 2017). In social work, intervention is the intentionally implemented change strategies, performed by the social worker. Intervention is delivered to impede risk factors, activate protective factors, reduce or eradicate harm, and introduce betterment (Sundell & Olsson, 2017). Social work intervention encompasses a wide range of psychotherapies, treatments, and programs. It ranges from simple to complex interventions with many elements that contribute to its effectiveness (Sundell & Olsson, 2017).

1.6.3. Mental health

Mental health, as conceptualized by the World Health Organization (WHO), is defined "as a state of well-being in which an individual realizes his or her abilities, can cope with the normal stresses of life, can work productively and fruitfully and can make a contribution to their community" (World Health Organisation, 2018:1).

1.6.4. Frontline social workers

A frontline social worker is a social service professional who engages in intervention with a client system to address their identified needs (Fook, 2002). Within the context of this study, a frontline social worker is a social worker, who is registered with the South African Council of Social Service Professionals (SACSSP) and delivers intervention to clients struggling with their mental health.

1.7. RESEARCH METHODOLOGY

The research methodology that was utilized for this study, is presented and discussed in this section. A definition and elaboration on the research approach, research design, method of sampling, data collection, and data analysis applied in this study is provided below.

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1.7.1. Research approach

A qualitative approach was used to reach the objective of this study. Qualitative methods seek answers by examining various social settings, groups, or individuals and are concerned with a participants' meanings, definitions, and descriptions of phenomena (Lune & Berg, 2017). The qualitative approach was useful to this study as it aimed to explore the influence of cultural beliefs on social work intervention in mental health. This study was concerned with the voices of frontline social workers employed in the field of mental health and aimed to gain an in-depth understanding of the influence of cultural beliefs on social work intervention in mental health.

1.7.2. Research design

Aligning with the qualitative research approach, this study utilized both descriptive and exploratory research designs. The goal of descriptive research is to describe phenomena and their characteristics (Nassaji, 2015). This design was useful to this study as both mental health and cultural beliefs are two dense phenomena that require comprehensive investigation by the researcher. Exploratory research designs are conducted to gain insight into phenomena and are promoted by a lack of basic information or by the need to become acquainted with phenomena (Fouche & Roestenburg, 2021). The exploratory research design was of great value to this study as it allowed for a comprehensive investigation of cultural beliefs and social work intervention as well as the relationship between the two phenomena, and the impact it has on mental health.

1.7.3. Sampling

A sample is a portion of a population that is representative of the population and possesses specific characteristics that are relevant to the aim of the research. The population for this study consisted of social workers registered with the South African Council of Social Service Professionals (SACSSP). Participants of the study were social workers who are employed in public and private sectors in the Western Cape and who deliver mental health intervention. Social workers belonging to varying cultures upholding varying cultural beliefs can be participants of this study. A nonprobability sampling technique was used. The type of nonprobability sampling used to select participants was purposive sampling. In nonprobability sampling

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subjective methods are used to produce a criterion that decides which participants are recruited to achieve the aim of this study (Etikan, Musa, Alkassim, 2016).

The criteria used for the inclusion of participants was as follows:

- A registered social worker with the South African Council of Social Service Professionals (SACSSP).
- A social worker who is employed in the field of mental health in the Western Cape.
- A social worker who has at least two years' experience in delivering the intervention in the field of mental health.
- Proficient in the English language.

Using the purposive sampling technique, the researcher set out to source participants from her professional network. The researcher has developed professional relationships with various social workers throughout her professional and academic career. The researcher drew a clear distinction with the potential participants between personal and professional communication and ensured that the professional relationship and boundaries were maintained (South African Council for Social Service Professionals, General Notice 6 of 2020). Those identified as per the criterion for inclusion were formally invited to participate in this study in their personal professional capacity. Once the participants' willingness to participate was confirmed, the researcher sent an informed consent form (attached as Annexure A) via email. All email addresses were verified to ensure that the researcher sent the required documents to the allocated participant. This form was signed by the participant before the researcher scheduled and initiated the one-on-one telephonic interview. All participants were interviewed during their personal time and not within their office or practice hours of their respective organizations. This ensured that the interviews did not interfere with the participants' work environments. This process of contacting potential participants from the researcher's professional network was continued until 20 participants were identified. Once all 20 participants were identified, the researcher scheduled appointments with all the participants. Leading from this, the empirical study was conducted in Cape Town, in the Western Cape, from the 1st of February 2021 until the 31st of March 2021.

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1.7.4. Instrument of data collection

Data gathering is fundamental to research as the gathered data contribute to a better understanding of the phenomena under research (Etikan, Musa & Alkassim, 2016). Although qualitative interviews are traditionally conducted on a face-to-face basis, the researcher collected data by conducting one-on-one telephonic interviews. Face-to-face interviews were no longer available to the researcher as this study has not been acknowledged by the South African Government, under the Presidential Regulations, as an essential service related to the COVID-19 pandemic. The use of telephone interviews for this study were well suited. Telephone interviews provided a more balanced distribution of power between the researcher and the research participants as it encouraged the participants to speak freely and gave them greater control. (Farooq & de Villiers, 2017).

The use of telephone interviews as a means of data collection for this study matched the strengths of both the participants and the researcher. Both the researcher and the participants rely on using the telephone as part of their work thus both are experienced and comfortable communicating using the telephone. The researcher is also a social worker and employed in an environment where all interactions are largely telephonically based, particularly as a result of the restrictions imposed by the COVID-19 pandemic. The researcher has also recently undergone training on Therapy in the Information Age which focused on the use of the telephone in therapeutic interactions (Bobevski, Holgate & Mclennan, 2007; Ee & Lowe, 2007). As a result, the researcher has developed skills and confidence to undertake telephonic qualitative research interviews. After attaining the participants' permission, the researcher used a mobile application called Cube ACR to record the one-on-one telephonic interviews. The collected data was then stored in a password-protected mobile device. Thereafter, it was transferred to the cloud services, Microsoft OneDrive. This cloud service requires a username and is password-protected, thus access to it was controlled and further secured. All handwritten notes relating to the data were stored in a locked cabinet at the researcher's residence. A semi-structured interview schedule (attached as Annexure B) was used to guide the interview between the researcher and the participants. A semi-structured interview schedule is made up of several predetermined questions, both open-ended and closed questions (Lune & Berg,

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2017). Each of the participants were asked these questions in consistent order. Furthermore, the use of the semi-structured interview schedule allowed the researcher to probe information and assisted in gaining an in-depth understanding of the participants' views (Lune & Berg, 2017).

1.7.5. Data analysis

Data analysis is concerned with reducing a large volume of information that the researcher has gathered and assists the researcher in making sense of the gathered data (Bryman, 2016). Tables and figures were used to profile the participants and clarify the context of the study. However, this did not transform this study into a quantitative research study. Following this, thematic analysis was used to draw conclusions for this study and thereafter assisted the researcher in making recommendations. Thematic analysis is defined as a process of interpretation of qualitative data to identify patterns of meaning (Crowe, Inder & Porter, 2015). Aligning with the procedure for thematic analysis, the following steps were used to analyse the data:

- The first step of data analysis was to convert all the audio-recordings of the interviews into a written format to form transcriptions. This close analysis of the data assisted the researcher to extract core themes (Bryman, 2016).
- The second step was the coding process. Through the coding process, the researcher identified trends in the data. These were words and phrases that were commonly repeated by research participants. The researcher thoroughly investigated the value of each of the repeated words and phrases.
- The third step of thematic analysis was focused on categorizing the trends in the data and therewith the identification of themes and subthemes. This assisted the researcher in making sense of the gathered data (Bryman, 2016).
- The fourth step of thematic analysis was directed towards the researcher's thoughts about the summaries of the gathered data.
- The final step of thematic analysis included all generalisations that could be derived from the gathered data. This constituted the empirical investigation, illustrated in chapter four of this study, and was used to draw conclusions and make recommendations that are displayed in chapter five.

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1.7.6. Data verification

Data verification enhances the quality of the data collected. Validity and reliability are two of the most important concepts in ensuring data verification. Validity refers to the extent to which empirical data accurately reflects the meanings of the concepts under investigation. Reliability refers to the accuracy of the researcher's ability to measure or derive meaning from the gathered data. Moreover, it is the extent to which the same conclusions can be drawn from the data if it were used in the same situation on repeated occasions (Heale & Twycross, 2015). Below, the credibility, transferability, dependability, and confirmability of all data attained, is discussed to prove the validity and reliability of this study.

- **Credibility**

The goal of credibility is to ensure the truthfulness of the research findings. It establishes whether there is a match between the views of the participants and the conclusions drawn by the researcher. It emphasizes the researcher's ability to draw a correct interpretation of the participants' views (Korstjens & Moser, 2018). Credibility was enhanced by ensuring that the participants met the criterion for inclusion for the study. Also, all the conclusions drawn and recommendations made in chapter four and five, respectively, are supported by the narratives of the participants.

- **Transferability**

The transferability of data is the degree to which the results can be transferred from one context to another. The goal of transferability is whether research findings can be generalized or transferred to alternating settings (Korstjens & Moser, 2018). In line with the aforementioned, the researcher promoted transferability by elaborating on the sample for the study and the criterion for inclusion in chapter one. This followed a detailed account of how the data was gathered and analysed in chapter one and four of this study. Furthermore, all conclusions drawn and recommendations made in chapter four and five of this study were supported by the participants' narratives and the respective literature.

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- **Dependability**

The dependability of research focuses on the data obtained from participants, the interpretation thereof, and the recommendations made by the researcher (Korstjens & Moser, 2018). It is concerned with whether the research process is logical, well-documented, and audited. The researcher ensured dependability of this study by providing narratives in support of all themes and subthemes presented in chapter four as well as for the conclusions drawn in chapter five of this study.

- **Confirmability**

The confirmability of research is concerned with the degree to which the research findings can be confirmed by other researchers. It ensures that the data and the interpretation thereof can be validated (Korstjens & Moser, 2018). For this study, confirmability was promoted as all themes and subthemes, as presented in chapter four of this study, were supported by the participants' narratives. Furthermore, all conclusions drawn in chapter five of this study were guided by the participants' narratives.

1.7.7. Reflexivity

The researcher is in the position as one with working knowledge of the field of study and as a social worker herself, and shares a professional identity with the participants. This practitioner-researcher position, upheld by the researcher, is valuable to this study and is valuable in developing insights (Reid, Brown, Smith, Cope, and Jamieson, 2018). However, this could also contribute to biases, therefore the researcher engaged in reflexivity throughout the completion of this research study. Reflexivity is the process of continual internal dialogue, critical self-evaluation, active acknowledgment, and explicit recognition that the researcher's position may affect the research process, data analysis, and the outcome of the study (Reid, Brown, Smith, Cope and Jamieson, 2018). It was the researcher's ethical responsibility to remain transparent about her influence on the development of the research and her engagement with the participants (Reid, Brown, Smith, Cope & Jamieson, 2018). To promote reflexivity, the researcher kept a journal in which she recorded her thoughts, feelings, uncertainties, values, beliefs, and assumptions that arose throughout the research process (Reid, Brown, Smith, Cope & Jamieson, 2018). The researcher also

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compiled a reflexivity report, attached as Annexure E. This report reflects the researcher's experience with the research topic as well as her entanglements throughout the research process.

1.7.8. Member-checking

Member-checking involves the return of data to the participants following data analysis (Gunawan, 2015). It is an opportunity for the participants to approve the interpretation of the data they provided throughout the interview process. It is also a way of confirming whether the data aligns with the participant's experiences. (Carlson, 2010). To ensure that the data obtained from the participants were valid and reflect their views, the researcher returned three transcripts to the respective participants and requested that they verify it's accuracy. These transcripts were chosen at random to validate the process of member-checking. The researcher also remained in constant contact with each of the participants throughout the completion of chapter four and five of this study. This ensured that the researcher's findings aligned with and were a true reflection of the views expressed by the participants.

1.7.9. Ethical clearance

Ethical clearance for this study is concerned with risk and harm to the participants, informed consent, anonymity, and confidentiality. Informed consent is the knowing consent of the participants, practicing free will, without any element of fraud, deceit, duress, incentive, or manipulation (Lune & Berg, 2017). As highlighted in Annexure A, confidentiality was both maintained and upheld by the researcher. Coupled with informed consent, none of the participants' personal identifying information was recorded and the data obtained from the participants was stored on both a password-protected laptop as well as within a password protected cloud (Microsoft OneDrive), registered in the researcher's name. The study was considered as a low-risk study as it aimed to explore the views of frontline social workers on the influence of cultural beliefs on social work intervention in mental health. For this reason, ethical clearance for this study was obtained from the Departmental Research Screening Committee (DESC) of the Department of Social Work at the University of Stellenbosch and the Research Ethics Committee of Stellenbosch University. The researcher received a letter of approval for this study, from the Research Ethics Committee of Stellenbosch

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University. This is attached as Annexure C. Alongside the letter of approval, the Research Ethics Committee of Stellenbosch University also clarified the researcher's responsibilities for and throughout the research process. This is attached as Annexure D. This document was useful in guiding the researcher's practise throughout this study as well as throughout the completion of the telephonic interviews with the participants. The participants of this study were adult social work professionals who shared their views about the research question. There was little potential for discomfort as the participants shared their views on behalf of their professional practice. Furthermore, the participants were not regarded as a vulnerable population, by research standards.

1.8. LIMITATIONS OF THE STUDY

It was imperative that the researcher explain and be aware of the limitations of the study (De Vos et al., 2011). According to Schurink, Fouche, and De Vos (2011) limitations are aspects that the researcher needs to be aware of, recognize, acknowledge, and present clearly. The first limitation of this study regarded the fact that culture is a poorly informed and untested variable in research (Singer et al. 2016). This made it difficult for the researcher to conceptualise and compare this study to other forms of literature. Moreover, there are few scholars that have investigated the topic, and of the ones that did, its focus missed social work interventions and evaluations of culturally based culturally appropriate methods of assisting individuals (Lund et al., 2012). The second limitation of this study was the sample size. The study's sample size was not large enough to make generalisations. This limitation is further accentuated when one considers that this study was only focused in Cape Town in the Western Cape. However, it is important to note that the research methodology used was meticulously described, in chapter one of this study, so that the study can be adopted to other areas in South Africa, as well as with a larger sample size. Furthermore, in considering that study was qualitative in nature, generalisations was not the primary goal of the study but rather the goal was to gain insight that could be used to inform and provide direction for future research on the topic of the study.

1.9. CHAPTER LAYOUT AND PRESENTATION

The research study consists of five chapters. The first chapter introduced the research study by focusing on the rationale, the problem statement as well as the aims and

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objectives of the study and the research methodology that was utilised. There are two literature review chapters in this study. The first, chapter two, explored the first objective of this study. Thus, it provided an overview of culture, conceptualized cultural beliefs and thereafter described its influence on social work intervention. Building on this, chapter three, the second literature review chapter, acknowledged that second objective of this study. In turn, it provided a critical analysis of the influence of cultural beliefs on social work intervention in mental health using Kleinman's explanatory model. Kleinman's explanatory model is the main underlying theoretical framework to this study. Leading from the aforementioned, chapter four encapsulated the empirical study and acknowledged the third objective of this study. This included the investigation of the views of frontline social workers regarding the influence of cultural beliefs on social work intervention in mental health. Furthermore, this chapter also provided narratives in support of the themes and subthemes that were identified through data analysis. The final chapter of this study, chapter five, discussed the conclusions drawn from the empirical study and also presented the respective recommendations.

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CHAPTER TWO

THE INFLUENCE OF CULTURE AND CULTURAL BELIEFS ON SOCIAL WORK INTERVENTION

2.1. INTRODUCTION

Towards understanding the influence of cultural beliefs on social work intervention, this chapter provides an overview of culture and thereafter defines cultural beliefs. The chapter further provides an in-depth discussion of social work and culture, and it also draws a focus on social work intervention in South Africa. Thereafter, the influence of cultural beliefs on social work intervention is elaborated on. This chapter serves as the foundation for the critical analysis of the influence of cultural beliefs on social work intervention in mental health.

2.2. DEFINING CULTURE AND CULTURAL BELIEFS

This study aimed to investigate the influence of cultural beliefs on social work intervention in mental health. However, understanding culture is significant as a point of departure. Therefore, an overview of culture is elaborated on below and includes the discussion of cultural values and attitudes. Cultural beliefs are defined thereafter.

2.2.1. Culture

Culture has been defined by many scholars and researchers in multiple disciplines. It is well recognised as a complex phenomenon, with an array of meanings (Alvarez-Hernandez & Choi, 2017). Culture is generally defined as a broad concept that includes the values, beliefs, expectations, practices, and ceremonies shared by a group of people (Zoabi & Savaya, 2012). In social work, Sheafor & Horesji (2006) define culture as a set of interrelated behaviours, beliefs, values, attitudes, and practices that is transmitted or communicated from generation to generation. According to Subudhi (2014) culture plays a vital role in directing, shaping, and modelling social behaviour at the individual, community, and societal levels. The way children are socialized is an excellent way to witness how culture is learned (Spencer-Oatey, 2012). Two babies born at the same time in two different parts of the world may be taught to respond to physical and social environments in very different ways (Spencer-Oatey, 2012). One baby may be taught to smile at strangers whereas the

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other will be taught to avoid interaction with strangers (Spencer-Oatey, 2012). In this way, culture is learned and used to shape our behaviours and beliefs. In the above context, the baby taught to smile may develop positive beliefs towards the stranger whereas the other, negative beliefs towards strangers. In acknowledging the aforementioned, culture plays a role in the psychological and behavioural development of individuals (Hatala, 2012). Culture is also a necessary part of prevention and healing for a large variety of individuals and is a protective factor for well-being (Kirmayer, Gone & Moses, 2014; Snowshoe, Crooks, Tremblay, Craig, Hinson, 2015).

2.2.2. Cultural values

According to Peeters (2015), the most important difference between cultures are not customs or traditions but rather cultural values. Cultural values are defined as values that appear to be widespread in a culture. Cultural values are commonly viewed as the abstract motivations that guide, justify and explain an individual's values (Schwartz, 2007; Vauclair & Fischer, 2011). Igboin (2011) aligns with the aforementioned and describes cultural values as the ideas that guide an individual's actions and refer to behaviours that are "good" or "desired". As a result, cultural values underpin the beliefs, views, attitudes and communication patterns that are associated with that culture (Peeters, 2015). They are the standard which individuals adhere to in their personal and communal interactions and may influence the extent to which groups of people care about the well-being of current and future generations of children (Kasser, 2011).

2.2.3. Cultural attitudes

According to Cherry (2021), an attitude refers to a set of emotions, beliefs and behaviours towards an object, person, event or illness. Attitudes are socially guided and emerge from experience, child-rearing, and one's culture (Boer and Fischer 2013; Cherry, 2021). In acknowledging the role culture plays in shaping attitudes, Kountouris & Remoundou (2016) elicit that culture is a significant determinant of an individual's attitudes. Thus, attitudes vary among cultures. Leading from the aforementioned, Boer and Fischer (2013), Balante, van den Boek & White, (2021) Cherry, (2021) and

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Lamkedem (2012) note that cultural attitudes have a powerful influence on behaviour, and in shaping thinking and feeling.

2.2.4. Cultural beliefs

Cultural beliefs is a component of culture, and the focus of this study, and is defined as an awareness or understanding of one's culture and that of others (Wolf, Wu, Spadaro & Hunker, 2020). It assists individuals to make sense of their world by providing a sense of safety, well-being, integrity and belonging (Kaur & Kaur, 2016; Singer, Dressler, George, & The NIH Expert Panel, 2016). Cultural beliefs play powerful roles in the everyday lives of individuals. It guides their actions, behaviours and determines how they perceive, think, and feel (Kaur & Kaur, 2016; Spencer-Oatey, 2012). As a result, cultural beliefs form a part of an individual's every encounter and every interaction (Bassett, 2011). In this way, it also characterizes groups of people and distinguishes them from one another (Kaur & Kaur, 2016).

2.3. SOCIAL WORK PRACTICE, INTERVENTION AND METHODS

Social work practice includes a range of direct social work intervention strategies with individuals, families, small groups, communities, policies, establishments and other human service agencies (Chukwu, et al., 2017). Extending from social work practice, social work intervention is defined as the application of social work theory and methods towards the resolution and prevention of psychosocial problems experienced by individuals, families and groups (Walsh, 2013). A method is what a social worker does when working with clients and this guides them on what to do when faced with a certain phenomenon (Teater, 2010). According to Uranta & Ogbanga (2017), social work methods are planned and systematic approaches of helping individuals in need that have been tested over a period of time. Thus, social work methods differ in their application of knowledge, skills and techniques (Chukwu, et al., 2017).

Social work methods are used by social workers to help people of all ages and assists individuals to cope more effectively with their problems, needs or challenges (Okoye, 2013). It is also used to enhance the social functioning of various societies. Although many social work methods have proven to be very effective in the western world, these same methods are often not as effective in some economic and socio-cultural

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environments (Chukwu, et al., 2017). The value of this critique of social work methods and Eurocentrism will be further discussed in this chapter. Below the six methods of social work are described and discussed. This is done in order to develop an understanding of both social work practice and social work intervention. Of the six that are discussed, the first three are those that are used to guide intervention with varying clients and the last three are those that support the intervention delivered to client systems. The six social work methods have been broadly grouped into two, namely primary and secondary methods of intervention.

2.3.1. Primary methods

Primary methods of social work practice are also referred to as direct helping methods (Chukwu, et al., 2017). Thus, it requires the social worker to intervene directly with his or her client at the individual, group or community level. Leading from this, primary methods of social work practise further divided into case, group and community work. Each of the aforementioned is discussed further below.

- Case work

Case work is the oldest method of social work practice. It is a unique method of problem-solving that assists an individual with his or her psycho-social problems and in adjusting their environment to become more satisfying to their needs (Chukwu, et al., 2017). It is the social worker’s responsibility, in case work, to help their clients to achieve personal and social goals. Social workers do so through using available resources in their client’s community, in the strength of their personality or from his or her social systems (Chukwu, et al., 2017).

- *Group Work*

Groups are a fundamental part of the human experience and social life. It allows people to develop more complex and large-scale activities, assists in promoting socialisation, education and also provides settings where relationships can form or grow. Group work, in social work practise, is founded on the ideology that people are enriched by interpersonal experiences, satisfying peer relationships, and shared decision-making (Uranta & Ogbanga, 2017). Social workers deliver intervention in different types of groups, namely social action, support, remedial, therapeutic or

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treatment groups and reciprocal groups (Chukwu, et al., 2017). According to Ambrosino, Hefferman, and Shuttlesmuth (2012), the goal of group work is to help improve an individual's well-being and thereby relieve personal suffering. This is largely because groups can enhance problem-solving capacity, prevent the development of serious social problems, restore and maintain the social functioning of individuals (Ambrosino, et al., 2012). The greatest advantage of group work is that it facilitates changes in a client's communication skills, self-awareness, reality assessment, and acquisition of societal values to further aid their life goals (Uranta & Ogbanga, 2017).

- Community Work

Community work is recognized as key in the social work profession (Chukwu, et al., 2017). Principles of social work, social justice, equality, human rights, empowerment and partnerships with individuals all advocate for community work (Chukwu, et al., 2017). Community work is the process by which a systematic attempt is made to improve relationships in a community (Kramer & Specht, 2013). The social worker, through the application of knowledge and skills, helps the community to identify problems or social issues, source resources for solving them, develop social relationships and helps the development of necessary programmes (Chukwu, et al., 2017). Community work, through following this process, can assist a community to become self-reliant and develop a co-operative attitude. The social worker can uphold varying roles in community work. These include the role of an enabler, advocate, educator and counsellor (Chukwu, et al., 2017). Each of these roles are further in chapter three of this study.

2.3.2. Secondary methods

Secondary methods of social work practice support the primary methods. Social workers, delivering secondary methods of intervention, indirectly assist individuals (Chukwu, et al., 2017). There are three secondary methods of social work practice. These include social action, social welfare administration and social work. Each of these are discussed below.

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- Social action

Social action is aimed at bringing about structural changes in a social system or to prevent adverse changes (Chukwu, et al., 2017). It addresses movements such as social, religious and political reform, social legislation, racial and social justice, human rights, freedom and civic liberty (Chukwu, et al., 2017). As a method of social work, social action acknowledges the philosophy of professional social work. In doing so, it does not blame people for their problems, believes in the dignity and worth of all, adopts a commitment to the capacity of all people to take action, and facilitates members to make choices (Chukwu, et al., 2017).

- Social welfare administration

Social welfare administration requires an understanding of both social welfare and administration. In acknowledging this, Friedlander (1997) as cited in Chukwu, et al. (2017), defines social welfare as an organized system of social services and institutions designed to aid individuals and groups to achieve satisfying standards of life and health. Administration is a universal process that involves organizing people and directing their activities towards a common goal or objective (Simon, 1978; Chukwu, et al., 2017). In considering the aforementioned, social welfare administration is a method of practice that looks for administrative and managerial skills among social workers (Chukwu, et al., 2017). It is a growing field whereby programmes are administered from an organisation to vulnerable, disadvantaged and those in the population who are aged, and socially excluded because of disabilities, mental health, and HIV/AIDS (Chukwu, et al., 2017).

- Social work research

Social work research is the systematic and scientific study of social problems. The objective of social work research is producing knowledge for planning and carrying out social work intervention (Chukwu, et al., 2017). It is a powerful tool in all social work settings and is useful to all methods of social work. Social work research is essential as it assists in the formulation of goals for change and in the design of intervention plans (Chukwu, et al., 2017).

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2.4. SOCIAL WORK INTERVENTION IN THE SOUTH AFRICAN CONTEXT

It is well acknowledged that social workers in South Africa are delivering intervention in multifaceted situations (Abdullah, 2015; Kindle, 2016; Shokane & Masoga, 2018). The South African context is elaborated on below. It includes a discussion on cultural diversity, culture and racism and thereafter, social work intervention in South Africa. These aspects are discussed to present a contextual framework for social work practice in South Africa.

2.4.1. Cultural diversity in South Africa

Van Der Merwe (1996), as cited in Johnston (2015), noted that cultural diversity in the South African context is not only vast but also peculiar. It is well acknowledged that the South African population embraces many cultures and as a result, many customs, traditions and languages. An illustration of cultural diversity in South Africa is presented below. This is presented through the describing language, norms and values and traditions. It is important to note that cultures share differences in languages spoken, the norms, values and traditions upheld, thus the discussion below will assist in further illustrating cultural diversity in South Africa.

2.4.1.1. Language

South Africa’s Constitution recognises eleven official languages (Sepedi, Sesotho, Setswana, siSwati, Tshivenda, Xitsonga, Afrikaans, English, isiNdebele, isiXhosa and isiZulu). However, seven non-official languages are also spoken in South Africa (sign language and many other indigenous languages) (Berg, 2012; Emuze & James, 2013; Johnston, 2015; Macleod, 2002; Shokane & Masoga, 2018; Sotshangane, 2002). According to Gopalkrishnan (2018), language is central to any culture and to cultural understanding. Aligning with the aforementioned, Varner & Beamer (2005) describe language and culture as being intertwined to one another and therewith shaping each other. Every time a word is chosen, or a sentence is formed, cultural choices are made. Thus, cultural literacy is needed to understand the language being used (Varner & Beamer 2005; Emuze & James, 2013). If language is used in the absence of the awareness of the cultural implications, communication may not be effective and the wrong message may be sent (Varner & Beamer 2005; Emuze & James, 2013). Thus, the non-verbal aspect of language is also influenced by culture. According to Stanton

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(2009) these include eye contact, appearance, posture, pitch, volume and dictation, accent, vocal tension, speed and the use of the pause and one's tone. Individuals, from varying cultures, need to be aware of these factors as it can cause problems in understanding and may be recognised as a sign of disrespect (Emuze & James, 2013). It can also play a role in promoting misconceptions and stereotyping of varying cultures (Emuze & James, 2013; Verwey & Du Plooy-Cilliers, 2003). The aforementioned describes the great impact culture has on language. It also illustrates what may be acceptable to one culture, may be regarded as disrespect to another. Thus, careful consideration must be taken when language is used. Furthermore, the discussion above illustrates the great diversity that extends from cultures in South Africa particularly, when one considers the number of varying languages that are spoken by its residents.

2.4.1.2. Norms and values

Norms include shared rules, customs, and guidelines that define how people should behave in varying social interactions (Kaur & Kaur, 2016). House, Kanngiesser, Barrett, Yilmaz, Smith, Sebastian-Enesco, Erut & Silk (2020) align with the aforementioned, and confirm that norms are behavioural standards shared and enforced by a group of people or a community. Norms are based on expectations about what others in the community or group do or think the individual should do. Thus, norms provide guidelines for understanding the behaviours of people who belong to the same culture (Kaur & Kaur, 2016). Similarly to norms, values are also key to understanding an individual's culture as it determines how an individual responds to any given situation or circumstance (Deresky, 2003; Khairullah & Khairullah, 2013). However, contrasting to norms, values are a culture's ideas about what is good or bad and right or wrong, what is important and what is not (Deresky, 2003; Khairullah & Khairullah, 2013). It is this understanding of the differences between good and bad that are imposed by values that cause people to behave differently in similar circumstances (Cateora, Gilly & Graham, 2011). It is clear from the above that both norms and values play a role in shaping an individual's behaviours. Thus, both norms and values should be taken into consideration when engaging with individuals from varying cultures. For example, what may be acceptable behaviour in one culture, may be forbidden in another. Furthermore, both norms and values assists

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in developing an individual's understanding and reasoning for their behaviours. In turn, this further enhances the differences between individuals who belong to varying cultures and further promotes cultural diversity in any given context (Khairullah & Khairullah, 2013).

2.4.1.3. Traditions

According to Macleod (2002) there are two major cultural influences in South Africa. These include communal and individualistic cultures. Communal cultures are found mostly in African cultures. These cultures place a high value on teamwork, conformity and a collective unit. Their focus is on achieving group goals for their families and their communities (Emuze & James, 2013). Individualistic cultures are often associated with Western cultures. These cultures place a higher emphasis on individual goals such as attaining wealth and status rather than group or familial goals (Emuze & James, 2013). Traditional cultural practices exist and are specific in both communal and individualistic cultures. It reflects the customs and beliefs held by the members of the cultural group that are passed from one generation to another (Maluleke, 2012).

Some traditional cultural practices are extremely beneficial to its members whereas others have become harmful. Those specifically identified as being harmful include early and forced marriages (*Ukuthwala*, as currently practiced), virgin testing, widow's rituals (*'U ku ngena*), female genital mutilation (FGM), breast sweeping and ironing, the primogeniture rule, practices such as "cleansing" after male circumcision, and witch hunting (Maluleke, 2012; Zimba, 2020). According to Maluleke (2012), these practices persist despite their harmful nature and their violation of national and international rights laws because they are not questioned or challenged. Thus, they are viewed as correct in the eyes of those enforcing and practising it. In considering the aforementioned, it can be stated that traditional practices, whether harmful or not, makes a culture unique when compared to another (Maluleke, 2012). Thus, when considering the variety of traditional cultural practices upheld by varying cultures, the diversity it promotes cannot be denied.

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2.4.2. Culture and Racism

Racism reflects institutional, social and cultural influences and can have a profound impact on individuals (Ali, et al, 2021; Henkel, Dovidio & Gaertner, 2006). According to Ali, Rumbold, Kapellas, Lassi, Hedges & Jamieson (2021), and Berman & Paradies, (2010) all forms of racism can lead to the social alienation of the individual, marginalisation, exclusion, a fear of public spaces, and a loss of access to services. Thus, racism has been defined as anything that maintains or exacerbates inequality of opportunity among ethno-racial groups (Ali, et al, 2021). They are varying forms of racism. Below, structural, interpersonal or individual, institutional or systematic, and cultural racism is discussed.

- <u>Structural racism</u>

Racism has long been argued to operate at multiple levels, ranging from the individual level to structural levels (Carmichael & Hamilton, 1967; Jones, 2000; Gee & Ford, 2011). Structural racism is defined as the macro level systems, social forces, institutions, ideologies and processes that interact with one another to cause and reinforce inequalities among racial and ethnic groups (Gee & Ford, 2011; Powell, 2008). It refers to the way societies foster racial discrimination through mutually reinforcing systems of housing, education, employment, income, benefits, credit, media, health care and criminal justice. This form of racism does not need the actions or intent of individuals for it to be enforced. According to Jones (2000) and Gee & Ford (2011) even if interpersonal racism and discrimination were eliminated, structural racism would likely remain. Thus, further promoting discriminatory beliefs, values, and the distribution of resources (Bailey, Krieger, Agenor, Graves, Linos & Bassett, 2017). Although structural racism may not explicitly acknowledge and differentiate between cultures, it imposes inequalities for specific racial and ethnic groups. It can be stated that these racial and ethnic groups may belong to varying or specific cultures. Thus, the value of structural racism in differentiating access and promoting inequalities between and across cultures cannot be denied.

- <u>Interpersonal or individual racism</u>

Informed by structural racism, interpersonal racism exists in everyday interactions (Desmond & Emirbayer, 2009; Teeger, 2015). These interactions include both blatant

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and subtle acts (Desmond & Emirbayer, 2009; Essed, 1991; Teeger, 2015; Waters, 1999). According to Pittman (2012), an example of subtle acts of interpersonal racism is a heightened surveillance of customers of colour in retail spaces. Thus, individual or interpersonal racism also includes components such as prejudice, stereotypes and discrimination (Dovidio, Brigham, Johnson, Gaertner, 1996; Henkel, Dovidio & Gaertner, 2006). Prejudice is defined as an unfair negative attitude toward a social group, or a person perceived to be a member of that group (Henkel, Dovidio & Gaertner, 2006). A stereotype is a generalisation of beliefs about a group or its members that is unjustified because it reflects faulty thought processes or overgeneralization (Henkel, Dovidio & Gaertner, 2006). Leading from this, discrimination is defined as a selectively unjustified negative behaviour towards members of the target group that involves denying individuals or groups of people equality of treatment (Ali, et al., 2021; Henkel, Dovidio & Gaertner, 2006).

In considering the aforementioned, interpersonal racism has a large impact on indigenous populations around the world. Interpersonal racism has the power to promote negative feelings and feelings of inferiority through denying groups dignity, opportunities, and freedom (Ali, et al., 2021; Bohman, 2010; Henkel, Dovidio & Gaertner, 2006). Interpersonal or individual racism may also extend to culture. Thus, prejudice, stereotypes and discrimination can negatively influence the interactions between members of differing cultural groups. This may further stem from a lack of understanding or knowledge about a given culture, particularly when the behaviour of members of a culture differs significantly to another. This indistinctly links to understanding cultural norms and values which was discussed earlier in this chapter.

- Institutional or systematic racism

Institutional or systematic racism symbolises a widely accepted racist ideology that involves the power to deny other groups the dignity, opportunities, freedoms, and rewards that are available to them. According to Ali, et al, (2021) and Rodat (2017), institutional racism is marked by extreme forms of segregation that often leads to unfair and differential access between members of a society. Explicit examples of institutional racism are the racial separation laws in American States up to the 1960s, and the apartheid regime in South Africa between 1948 to 1994 (Rodat, 2017). The

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apartheid regime in South Africa used biological characteristics to oppress groups of people (Baldwin-Ragaven, de Gruchy, and London 1999; Dominelli, 2008; & Johnston, 2015). These biological characteristics included skin colour, eye colour and shape and hair types (Leighton & Hughes, 1961; Fernando, 2010; Rugman, 2013). As a result, groups of people were ranked in terms of superior and inferior (Gopalkrishnan, 2018). This has placed a strain on the contact between varying cultures and races and has negatively impacted the cultural relations between South Africans today (Southwood & Van Dulm, 2015). Jones (1997) and Henkel, Dovidio & Gaertner (2006) align with the aforementioned and confirm that when a racial group and its members have been historically disadvantaged, the consequences are broad, severe, and often reproduce themselves across time. Thus, institutional or systematic racism is a clear example of how racism can negatively impact relations between people of varying cultures.

- Cultural racism

According to Babacan & Gopalkrishnan (2007), newer forms of racism have superseded the previous forms of racism, particularly in South Africa. These newer forms of racism are built on culture and thus promote cultural superiority and inferiority (Babacan & Gopalkrishnan 2007). Besides the negative attitudes and beliefs that are implicit to all forms of racism, this newer form of racism has also resulted in the discrimination and differential treatment of individuals belonging to certain cultural groups (Gopalkrishnan, 2018). Cultural racism is defined as the phenomenon that occurs when an ethnic group or a historical collective attempts to dominate, exclude or eliminate another group on the basis of differences (Frederickson, 2011; Rodat, 2017). This form of racism is often subtle and difficult to detect (Henkel, Dovidio & Gaertner, 2006). However, some forms of cultural racism are explicit and harmful. According to Rodat (2017), these include ethnocentrism and xenophobia. Ethnocentrism is based on the identification of an individual with a group and the certainty of one's own superiority of several values, opinions or ideas. It is considered as an attitude, a mental disposition, or a behaviour which is accompanied by the rejection of cultural diversity (Ferreol, 2005; Rodat, 2017). Xenophobia refers to fear, hatred, and resentment to everything that is foreign or different (Taguieff, 2005; Rodat, 2017). It contains negative views against certain cultural or ethnic groups or against all other ethnic groups (Jucquois, 2005; Rodat, 2017). In considering the

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aforementioned, cultural racism is an individual's worldview that can become a rule (Rodat, 2017). Thus, cultural racism is more than feelings, attitudes and behaviour but rather an ideology of superiority and inferiority that can negatively impact the well-being and lives of those who are inferior.

2.4.3. Social work intervention in South Africa

South Africans today, reside in a milieu of past national trauma, intensified circumstances of poverty, unemployment, violence, social inequality, and a persistent lack of effective service delivery (Abdullah, 2015). The aforementioned are the harsh consequences of the apartheid regime (as discussed earlier in this chapter) (Abdullah, 2015). These conditions have had a significant effect on the intervention offered by social workers (Abdullah, 2015). According to Smith (2014) the origins of social work in South Africa are found within the forces of racist capitalism, social conflict and unequal power relations. As a result, social work in South Africa has a long history of grappling with culture and diversity as well as the ability to provide intervention to meet the needs of the population (Johnston, 2015). To address these challenges, social work intervention in South Africa is unique in that the developmental approach to social work was adopted as a national government policy in 1997 after the apartheid regime was abolished (Patel & Hochfeld, 2013).

The foundation of this approach is the South African government's constitutional obligation to address the inequality and discrimination imposed by the apartheid regime (Patel & Hochfeld, 2013). Furthermore, the importance of diversity was identified by the White Paper for Social Welfare as being fundamental to the developmental approach to social work (RSA, 1997). This was done because South Africa's history of apartheid was not conducive to assisting with the social and psychological traumas of those who experienced the harsh conditions of the apartheid regime. (Abdullah, 2015). As a result, social welfare programmes and thus, social work intervention delivered in South Africa, corresponds to the diverse social, cultural, and economic conditions of communities (RSA, 1997:10; Mayer & Viviers, 2015). At the policy level, The South African Council for Social Service Professionals Policy supports social work intervention that acknowledges diversity (South African Council for Social Service Professionals, 1978). According to Amuyunzu-Nyamongo (2013),

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this is essential to improve the needs of South Africans as it is viewed as a means of breaking down past racial and cultural barriers between diverse communities (Abdullah, 2015). Furthermore, Asmal, Mall, Kritzinger, Chiliza, Emsley & Swartz (2011) and Shokane & Masoga (2018) stress that intervention delivered in the South African context is successful only if it acknowledges diversity. This is largely because what is considered as well-being or living well, differ between individuals and their cultural contexts (Rugman, 2013). In acknowledging the diversity of the South African population, multiple methods of social work intervention are considered appropriate (Patel & Hochfeld, 2013). These include intervention delivered at the micro-level, meso-level, and macro-level with social workers delivering primary and secondary methods of intervention to individuals, their families, and in communities. The service provisions, depending on the area of specialisation of the social worker, span across rehabilitative, protective, preventative, and developmental goals (Patel & Hochfeld, 2013). It includes case, group and community work, as discussed earlier in this chapter.

2.3. SOCIAL WORK AND CULTURE

According to Rankopo & Osei-Hwedie (2011), social work is moulded to suit different cultures. To acknowledge and give value to the aforementioned, social work and culture is discussed below. The discussion includes an analysis of social work values, thereafter, cross-cultural practice concepts that are useful to multicultural practice in social work are discussed. Lastly, culture and mental health is explored and discussed.

2.4.1. Social work values and culture

Social work values govern the practise of social workers and ensure that they demonstrate an understanding of and respect for culture and diversity (NASW, 2015). There are several values in social work. These include service, social justice, dignity and worth of the individual, importance of human relationships, integrity and competence (NASW, 2021). However, only dignity and worth of the individual, social justice, and competence are discussed below. These values are most prominent to respecting and understanding culture in social work practice and intervention.

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2.4.1.1. Dignity and worth of the individual

According to the International Federation of Social Work and International Association of Schools of Social Work (2014), social workers must recognise and respond effectively to people of different cultures, ethnic backgrounds, religions, social classes and other diversity factors. The National Association of Social Workers (NASW) (2021) align with the aforementioned and agree that social workers should treat each person in a caring and respectful manner, mindful of individual differences, cultural and ethnic diversity. When social work practice aligns with the aforementioned, it not only promotes social work intervention that is cognisant of culture and diversity but also acknowledges an individual's human rights, as enshrined in The Bill of Rights (Chapter Two of the Constitution of the Republic of South Africa) (RSA, 1996). There are five core notions of human rights. These include human dignity; non-discrimination; civil and political rights; economic, social and cultural rights (Wronka, 2007; RSA, 1996; Rozas & Garran, 2016).

In acknowledging an individual's cultural rights, social workers accept that, all individuals have a right to access their culture, to cultural identity, to identification with a cultural community, to participation in cultural life, to education and training; to information, and to cultural heritages (Rozas & Garran, 2016). Cultural rights further extends to acknowledge that culture influences an individual's experiences, their understanding and their behaviours (Zoabi & Savaya, 2012). It is thus imperative that social work intervention acknowledge and include local cultural practices, norms, morals and values in intervention. This further ensures that social work intervention not only supports an individual's human rights but also does not promote unfair discrimination and acknowledges the dignity and worth of individuals (Boston, Dunlap, Ethridge, Barnes, Dowden & Euring, 2015; Shokane & Masoga, 2018).

2.4.1.2. Social justice

Social workers have a responsibility to promote social justice in relation to societies and to the people they work with (Littlechild, 2012). Through valuing social justice, social workers pursue social change with and on behalf of vulnerable and disadvantaged individuals, families, groups and communities that they work with (South African Council for Social Service Professionals, Policy Guidelines For Course

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of Conduct, Code of Ethics and the Rules for Social Workers, Social Service Professions, 1978). In promoting social change, social workers are focused primarily on the discrimination of individuals, families, group and communities (NASW, 2021). Thus, social work practise aims to challenge negative discrimination on the basis of characteristics such as ability, age, culture, gender or sex, marital status, socio-economic status, political opinions, skin colour, racial or other physical characteristics, sexual orientation or spiritual beliefs (Littlechild, 2012). In doing so, social workers deliver interventions that seek to promote insight, sensitivity and respect for cultural and ethnic diversity (Littlechild, 2012; Lotfi, 2019). In turn, this promotes non-discriminatory social work intervention and prompts the social work to promote the dignity and worth of the individual, as discussed above.

2.4.1.3. Competence

Social workers have an ethical responsibility to understand culture and how to work positively with different cultures (Littlechild, 2012). In social work practice, this equips social workers with a knowledge base of their client's cultural background and assists them in delivering services that are sensitive to the client's culture. Moreover, knowledge about a client's cultural background assists the social worker in understanding their behaviours, their society, their strengths and at times, their weaknesses (NASW, 2021). This allows the social worker to deliver intervention that is competent to a given culture and unique to the individual they are assisting. However, in promoting competence, social workers also need to engage in introspection. According to the South African Council for Social Service Professionals, Policy Guidelines For Course of Conduct, Code of Ethics and the Rules for Social Workers, Social Service Professions Act (1978) social workers should strive to be aware of their own belief systems, values, needs and limitations as well as the effect it has on their work. This ensures that social workers raise awareness of their own perspectives and biases. (Asmal, et al., 2011). Leading from this, National Association of Social Workers (2021), stress that social workers should continually strive to increase their professional knowledge and skills in order to adequately deliver social work intervention to a vast population of people (Littlechild, 2012). This also assists social workers to avoid unfair discrimination against culturally different groups,

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promote social justice, and respect the dignity and worth of all individuals, as discussed above.

2.4.3. Cross-cultural practice concepts in social work

The diversity of patients, problems, beliefs and cultures challenge social workers to see themselves as the other and also recognize their responsibility in gaining knowledge about varying cultures (Marsiglia & Booth, 2018). To further assist social workers, many debatable cross-cultural practise concepts exist and play a role in promoting multicultural social work practice. However, only cultural awareness, cultural sensitivity, cultural appropriateness, cultural safety, cultural competence and cultural humility are discussed below.

2.4.3.1. Cultural awareness

Cultural awareness refers to a social worker's ability to gain specific knowledge about a client's cultural background, experiences, values, spiritual beliefs, world-view, customs, communication patterns, thinking patterns and coping practices (Walsh, 2013). Humility and respect, on part of the social worker, are necessary to achieve cultural awareness. Cultural awareness assists social workers in developing workable strategies for meeting the goals of a cross-cultural working relationship (Dean, 2001; Danso, 2018).

2.4.3.2. Cultural sensitivity

Cultural sensitivity refers to a social worker's attitudes and values about cross-cultural practice. It refers to his or her ability to effectively deliver intervention to individuals belonging to different cultures (Walsh, 2013). Cultural sensitivity assists social workers to become more sensitive, connect empathically with clients and maintain awareness of his or her own personal experiences that might hamper their judgement in delivering intervention (Walsh, 2013).

2.4.3.3. Cultural appropriateness

Cultural appropriateness begins with an assessment of whether the existing evidence-based interventions are suitable to the client. It includes an examination of the client's cultural context and involves adapting intervention, when necessary, without

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compromising its effectiveness (Marsiglia & Booth, 2018). This ensures that intervention is relevant to and engaging for clients from diverse cultural backgrounds (Marsiglia & Booth, 2018). In ensuring the cultural appropriateness of intervention, social workers produce a more equitable and productive professional relationship with their clients (Marsiglia & Booth, 2018).

2.4.3.4. Cultural safety

Cultural safety involves the systematic modification of intervention to consider the culture of a client system. It is done to ensure that intervention is cognisant of the client's cultural patterns, meanings and values. Furthermore, it involves tailoring intervention to suit the client's cultural beliefs and values (Walsh, 2013).

2.4.3.5. Cultural competence

Cultural competence is considered an ethical imperative and a central tenet of social work practise (Zimba, 2020). It is a broad concept that addresses social justice and service delivery quality, equity, access and efficacy for individuals and groups of diverse backgrounds (Cross, 2013). Cultural competency has the potential for increasing the effectiveness of interventions by incorporating an individual's culturally based values and norms and their diverse ways of knowing (Marsiglia & Booth, 2018). It accepts that people have their own ways of seeking and receiving assistance and these should be respected (Walsh, 2013). Social workers acquire cultural competence through two simultaneous processes namely, acculturation and deculturation.

Acculturative practices enable the social worker and the client to adapt to each other's cultural values, beliefs, and practices in mutually respectful ways while at the same time discarding, through deculturation, negative aspects of their respective cultures that could hamper the professional relationship (Danso, 2015). Cultural competence stands prominent among multi-cultural practise concepts. However, it has also faced sharp criticism (Furlong & Wight, 2011). Cultural competence has been blamed doing the bare minimum (Furlong & Wight, 2011; Herring, Spangaro, Lauw, & McNamara, 2013), for assuming the social worker is from a dominant culture, for treating culture as a neutral phenomenon, and for lacking power analysis (Garran & Rozas, 2013; Sakamoto, 2007). Furthermore, according to Ogundare (2020), an in-depth

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understanding of varying cultural groups does not confer competency as everyone is unique in terms of cultural identity.

2.4.3.6. Cultural humility

Cultural humility aims to attain a fully inclusive understanding of client's backgrounds, perspectives, and experiences (Melendres, 2020).Two components make up cultural humility, namely intrapersonal and interpersonal dimensions (Hook, 2014). The intrapersonal dimension requires social workers to develop awareness of the limitations in their ability to understand a client's worldview and cultural background (Hook, 2014). The interpersonal dimension requires social workers to take the position of the "other" and display respect and openness to their client's beliefs and worldview (Hook, 2014). However, despite its best interests, cultural humility has not received widespread acknowledgment in the social work profession (Danson, 2018). It has also been critiqued for having the same fundamental ideas as anti-oppressive social work (Healy, 2005).

2.4.4. Culture and mental health

Cultural diversity across the world has a significant impact on varying aspects of mental health. This ranges from the ways in which health and illness is perceived, an individual's health seeking behaviour and the attitudes upheld by the individual, mental health professionals and mental health systems (Gopalkrishnan, 2018). More extensively, these attitudes may promote stigma towards those with a mental health diagnosis and also discrimination. This has negative implications for the promotion of mental health. Below, the role culture plays in the stigma, discrimination and attitudes towards mental health is discussed.

2.4.4.1. Stigma

Although public knowledge about mental health has increased, stigma against individuals diagnosed with mental health remains constant. According to Hinshaw (2007) and Bharadwaj, Pai and Suziedelyte (2015), mental health is ranked low in terms of public acceptance. Stigma is defined as the "mark of shame", disgrace or disapproval which results in an individual being rejected, discriminated against and excluded from participating in varying areas of a society (WHO, 2001). For some

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cultures, stigma towards mental health is higher than in others. This is because health and illness are perceived differently across cultures (Gopalkrishnan, 2018). In turn, stigma can play a role in whether people are motivated to seek treatment, how they cope with their symptoms, how supportive their families and communities are, where they seek help, the pathways they take to access services and how well they fare in treatment (Hernandez, Nesman, Mowery, Acevedo-Polakovich & Callejas, 2009). Different types of stigma exist and range from public (externalized or experienced stigma) to self-stigma (Corrigan, Kerr & Knudsen, 2005; Egbe, Brooke-Sumner, Kathree, Selohilwe, Thornicroft & Petersen, 2014; Rusch, Angermeyer & Corrigan, 2005). The aforementioned types of stigma are interlinked and one often leads to the other. However, the overall effects of stigma on people with mental health cannot be denied and are far reaching (Egbe, et al., 2014). According to research conducted by Thornicroft, Brohan, Kassam, Lewis-Holmes (2008), Kahng & Mowbray (2005), Starkey & Raymond (1997), and Eisenberg, Downs and Golberstein (2012), stigma can exacerbate low self-esteem, marginalization from society, social isolation, social anxiety, poor social skills, difficulties in securing employment, and poor social support.

Although fear of stigma does not result in behavioural or symptom change, Bharadwaj, Pai and Suziedelyte (2015) stress that it leads to individuals attempting to hide behaviours, actions or symptoms. This is often associated with feelings of shame (USDHHS, 2001). Hechanova & Waelde (2017) agree with the aforementioned and confirm that shame is one reason why individuals are slow or refrain from assistance from mental health care professionals. Shame may extend from the family or the community the individual resides (Gopalkrishnan, 2018). However, according to Fernando (2014), shame extended from family members may be more severe for the individual because their family is often the only support individuals have. Moreover, when support from the family is absent due to stigma or shame, it can lead to the total neglect of the individual thus abandoning them with their mental health.

2.4.4.2. Discrimination

For the context of this study, discrimination will be discussed in two ways namely the discrimination that extends from mental health theory and practice and the

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discrimination experienced by members from other members of their cultural group. Each of these will be discussed individually.

- *Discriminatory mental health theory and practice*

The majority of the theory and practice of mental health thus including both psychiatry and mainstream psychology extends from Western cultural traditions and Western understandings of human life (Gopalkrishnan, 2018). 2018). In light of the aforementioned, mental health professionals may be seen as playing a role in promoting discriminatory mental health services because a monocultural understanding of mental health is problematic when applied to the context of non-Western cultures (Bessarab & Crawford, 2013; Gopalkrishnan, 2018). A monocultural understanding of mental health fails to consider the complexity of mental health service delivery across cultures (Gopalkrishnan, 2018). In further consideration of the influence of Western approaches in mental health, the National Child Trauma Stress Network (2005) stresses that the concepts of normality and abnormality cannot be easily generalized to varying cultures. The use of these concepts can lead to mental health professionals overlooking, misinterpreting, stereotyping or mishandling their contact with individuals from differing cultural groups (Kline & Huff, 2007; Gopalkrishnan, 2018). This can impose mainstream bias and stereotyping of cultural groups in mental health care which further lead to interventions that are inadequate and inappropriate (Ahmad & Bradby, 2007: Fernando, 2010).

- *Discrimination that extend from one's culture*

According to Helman (2007) the causes for mental health, across cultures, differ significantly. These differences range between the individual level, the natural world and the social world. These consultations, if made known to the community or cultural group, is often associated with discrimination, shame and labelling of the individual. According to Gopalkrishnan (2018), all individuals have the desire to protect their family's reputation and their dignity, thus they refrain from meeting with mental health professionals due to the fear of being labelled as "crazy". Therefore, the assistance for mental health lies beyond medical assistance and rather in consultation with traditional healers, elders or other significant people in the community (Gopalkrishnan, 2018). However, this form of assistance does not come without some forms of

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discrimination. Mental health for some cultures, is ascribed to possession by spirits, black magic, or the breaking of taboos. Familial or community knowledge of this may place the individual at risk of being labelled as “crazy” or “possessed”. According to Nguyen & Bornheimer (2014) this fear of being labelled as “crazy” is also often associated with “loss of face” which implies having lost the respect of other people as a result of doing something improper or unacceptable, thus promoting a lack of trust of the individual by members of their community or family group (Gopalkrishnan, 2018).

2.4.4.3. Attitudes

Mental health providers and professionals across the world have to work with clients that are often from cultures different to their own. Thus, a number of areas need to be taken into consideration by the mental health professionals if they wish to deliver successful intervention and effectively engage with all the people that they work with (Gopalkrishnan, 2018). This is largely because culture influences an individual’s attitudes around what is considered as mentally healthy and unhealthy, the way health and illness is viewed, treatment seeking patterns, and the nature of the therapeutic relationships (Amuyunzu-Nyamongo, 2013; Gopalkrishnan, 2018; Karthick & Barwa, 2017). Furthermore, attitudes also influence the way care is perceived as well as the quality thereof (Lamkadem, et al.,, 2012). Thus, a low perceived quality of care may lead to non-adherence to medical prescriptions or guidelines, lack of attendance to mental health professionals, and negative health outcomes (Lamkadem, et al., 2012).

Aligning with the aforementioned, Spagnolo, Champagne, Leduc, Rivard, Piat, Laporta, Melki & Charfi (2018) confirm that attitudes have important implications for individuals. They may discourage individuals from seeking mental health care and limit their access to quality interventions. Coping and resilience are other areas to consider when acknowledging an individual’s attitudes towards mental health (Gopalkrishnan, 2018). Coping styles refers to the way that people cope with everyday stressors as well as other, more extreme stressors. These also include mental health related stressors (Gopalkrishnan, 2018). As a result, cultural groups show major differences in terms of the types of stressors that they experience and how they assess their stressors. Furthermore, they will allocate social resources differently, leading to

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diverse experiences of these stressors. These differences in terms of dealing with stressors can be a protective factor and a risk factor for mental health thus they should be taken into consideration (Gopalkrishnan, 2018).

2.4.5. The influence of cultural beliefs on social work intervention

In order to best understand the influence of cultural beliefs on social work intervention, this section is split into two sub-sections. These sub-sections include a brief discussion of Eurocentrism and indigenization, thereafter the influence of cultural beliefs on social work intervention is explored. A discussion of Eurocentrism and indigenization is essential to this study and also further motivates the inclusion of cultural beliefs in social work intervention.

2.4.5.1. Eurocentrism and Indigenization

Eurocentrism is the discourse that places emphasis on European concerns, cultures, and values at the expense of other cultures. It assumes that Europe is civilized and has been throughout history thus it should have permanent superiority over all other cultures (Xypolia, 2016). Many authors (Bessarab & Crawford, 2013; Rankopo & Osei-Hwedie, 2011; Schiller & De Wet, 2019; Zoabi & Savaya, 2012) have acknowledged the extensive influence Eurocentrism has had on the social work practise and intervention. For this reason, social work practise in South Africa, has frequently been criticised for using European knowledge models to assist individuals (Schiller & De Wet (2019). Rankopo & Osei-Hwedie (2011) stress that social work practise, in South Africa, must be organised and should function differently.

Fernando (2014a) aligns with the aforementioned and argues that social work practise in South Africa, should start by asking people what they want and value. In this way, local indigenous knowledge can be used to guide the development of intervention and other relevant systems (Boksa, Joober and Kirmayer, 2015). This search for indigenous knowledge and thus indigenization, is driven towards freeing the social work profession from the dominance of European cultures and Eurocentrism (Rankopo & Osei-Hwedie, 2011). Furthermore, it calls for social workers in South Africa to continually engage in learning, regular training in local cultural differences, and in the customs of traditional healing systems. In turn, this will assist social work to

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promote indigenization and also to acknowledge culture and cultural beliefs in social work intervention. The advantages of acknowledging cultural beliefs in social work intervention is discussed below.

2.4.5.2. Cultural beliefs and social work intervention.

It is becoming increasingly important to work toward more culturally relevant ways of engaging with communities (Bin-Sallik, 2003; Sakamoto, 2007; Pon, 2009). As discussed above, culturally relevant intervention and indigenization is a way of freeing social work intervention, in South Africa, from Eurocentrism. Below, the influence of cultural beliefs on social work intervention is discussed. It includes a discussion of the advantages of including cultural beliefs in social work intervention as well as the implications of its absence in social work intervention. Social workers often find themselves assisting individuals with culturally contingent things such as family relationships, the care of children, the care of adults who need assistance in daily life, community well-being and other related issues (Rugman, 2013). Thus, a better understanding of cultural beliefs and the way diverse cultural groups cope with stressors can only but improve social work intervention (USDHHS, 2001).

Asad & Kay (2015) align with the aforementioned and confirm that intervention that accommodates cultural beliefs is more likely to be effective than those who do not. In acknowledging cultural beliefs in social work intervention, social workers show appreciation towards the strengths of different cultures, their cultural beliefs, and their practices (Littlechild, 2012). It also assists social workers in becoming more attentive to the nonverbal behaviours of their client system, their personal space, the roles upheld by family members, and how families arrange themselves (Asmal, et al., 2011). Cultural beliefs will not only play a role in social work intervention but also the professional relationship shared between the social worker and his or her client. Thus, social workers cannot deliver intervention successfully without careful consideration of the implications it has for the professional relationship (Marsella, 2011). When acknowledged in the professional relationship, cultural beliefs assist the social worker in promoting dignity and respect and further assists them in recognizing the value and worth of individuals, their families, and their communities (Ugiagbe, 2015). It also promotes a greater understanding between the social worker and his or her client

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system, plays a role in building rapport, trust and encourages compliance to the requirements of intervention (Abdullah, 2015; Mayer & Viviers, 2015). In its absence, cultural beliefs can raise issues of mistrust and unintentionally promote discrimination (USDHHS, 2001). This may also further disable an individual by prompting premature termination and non-compliance to social work practices (Asmal, et al., 2011; Schiller & De Wet, 2019). Furthermore, in failing to respect and acknowledge cultural beliefs, social workers can portray insensitivity, and a lack of awareness which can further result in a misidentification of the client's need (Asmal, et al., 2011; Schiller & De Wet, 2019). Thus, there can be severe repercussions for individuals and communities if social workers are not able to work effectively across cultures and include cultural beliefs in social work intervention (Gopalkrishnan, 2018).

2.5. CONCLUSION

As highlighted in this chapter, it is well acknowledged that social work intervention in South Africa requires an acceptance of both culture and diversity. This ensures that social work intervention responds to the culturally diverse South African population but also attempts to provide services to the large majority of South Africans who had been previously denied these services. Furthermore, this chapter also explored the varying cross-cultural practice concepts that can be used by social workers to ensure that their practice is cognisant of, and aligns with varying cultures. This chapter also further highlighted that the positive effects of acknowledging cultural beliefs in social work intervention far outweigh the negatives. In turn, failing to acknowledge cultural beliefs in social work intervention can have harsh consequences for an individual, may place them at greater risk and as a result, individuals may not seek intervention due to fear of discrimination. This may cast social work intervention in a negative light and prompt individuals to disregard it as an essential service.

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CHAPTER THREE

A CRITICAL ANALYSIS OF THE INFLUENCE OF CULTURAL BELIEFS ON SOCIAL WORK INTERVENTION IN MENTAL HEALTH USING THE EXPLANATORY MODEL

3.1. INTRODUCTION

This chapter provides a critical analysis of the influence of cultural beliefs on social work intervention in mental health using Kleinman's explanatory model. The chapter begins with conceptualizing mental health and thereafter describes the common mental health disorders. It draws focus on mental health in South Africa and describes social work, social work intervention and the roles of social workers in mental health. Thereafter, it provides an overview of Kleinman's explanatory model and discusses the influence of cultural beliefs on social work intervention in mental health.

3.2. CONCEPTUALISING MENTAL HEALTH

To understand the influence of cultural beliefs on social work intervention in mental health, using Kleinman's explanatory model, a clear description of mental health must be provided. Below, mental health is defined. This is followed by the common mental health disorders and the description of the approaches to mental health.

3.2.1 Defining mental health

Mental health is recognised as a valued source of human capital or well-being in a society. The World Health Organisation (WHO) defines mental health as "a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community" (WHO, 2018:1). Although the above definition is complimented for moving away from the conceptualisations of mental health as the absence of mental illness, it has often been criticised. According to Galderisi, Heinz, Kastrup, Beezhold, Sartorius (2015), the World Health Organisation (WHO) identifies only positive feelings and functioning as key factors for mental health. Furthermore, attaining a consensus for mental health is challenging. This is largely due to the vast differences between countries, their values, cultures and social backgrounds (Galderisi et al., 2015). In aim to address the aforementioned, Galderisi, Heinz,

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Kastrup, Beezhold, & Sartorius (2015) proposed the following definition for mental health: "mental health is a dynamic state of internal equilibrium which enables individuals to use their abilities in harmony with universal values of society. Basic cognitive and social skills; ability to recognize, express and modulate one's own emotions, as well as empathize with others; flexibility and ability to cope with adverse life events and function in social roles; and harmonious relationship between body and mind represent important components of mental health which contribute, to varying degrees, to the state of internal equilibrium".

Barlow & Durand (2012), Daniels (2018) & Ornellas, (2014) align with the aforementioned definition and agree that mental health is determined by multiple interacting social, cultural, psychological, and biological factors. Furthermore, the Mental Health Care Act, No 17 Of 2002, defines and acknowledges that the mental well-being of an individual is affected by physical, social and psychological factors (RSA, Mental Health Care Act, No 17 Of 2002:10). In considering the aforementioned, it can be stated that mental health, and its definition is largely subject to the cultural and social context of the individual who may be experiencing mental health challenges. As a result, it is challenging to establish a concrete definition for mental health which makes allowances for all respective cultural, social and religious aspects (Ornellas, 2014; WHO, 2001).

Further complicating the challenge of defining mental health is the competing psychological theories that influence mental health (Ornellas, 2014; WHO, 2001). Barlow & Durand (2012) agree that mental health can also be viewed as being a branch of medicine which focuses on the achievement and maintenance of mental, psychological and emotional well-being. For the purposes of the study and to acknowledge all aspects that may influence mental health, mental health will be defined as an unstable continuum where an individual's mental health may have different possible values and or meanings (Barlow & Durand, 2012; Ornellas, 2014).

3.3. APPROACHES TO MENTAL HEALTH

In conceptualizing and understanding mental health, basic knowledge of the various approaches to mental health must be highlighted as it influences aspects such as its

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causes, the onset, the nature, and the intervention delivered (Ornellas, 2014). Below, the medical model, biopsychological model, and social model is discussed.

3.3.1. The Medical model

Medicine, psychology, and psychiatry have always opted for the medical model for explaining mental health, distress, illness, and disease (Jacob, 2017). The medical model assumes that ill mental health diagnoses are biologically based brain illnesses and that the environment does not impact it (Lotfi, 2019). It emphasizes the diagnosis and naming of the mental illness as the initial step in investigating the cause and the treatment thereof (Lotfi, 2019). According to the medical model, the only way to treat ill mental health is through medication. Despite the dominance of the medical model, it has been critiqued for being too simplistic (Jacob, 2017). Furthermore, evidence exists to suggest that environmental stress and social determinants significantly impact mental health (Jacob, 2017).

3.3.2. The Social model

The social model assumes that there are two approaches to the prevention of mental health. The first approach aims to decrease risk factors and the second aims to promote protective factors (Lotfi, 2019). In this way, it advocates for alternatives to the medical model and acknowledges the social aspects that may give rise to the onset of a mental health diagnosis (Johnson, Meyer, Winnet & Small., 2000). These social aspects include socio-economic factors such as poverty and social deprivation (Barlow & Durand, 2012; Johnson et al., 2000; Lund et al., 2012; Skeen, Kleintjes, Lund, Petersen, Bhana, Flisher, 2010). The social model also acknowledges and aims to understand the history and upbringing of the individual, the influence of risk factors and coping mechanisms at the time of the onset of ill mental health, and the existing social support which is available to the individual (Barlow & Durand, 2012; Johnson et al 2000; Lund et al., 2012). The social model is often not the most popular choice for intervention due to the expertise it requires. It is often referred to as being a time-consuming approach (Jacob, 2017).

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3.3.3. The Biopsychosocial model

The biopsychosocial model assumes that physical, psychological, and the conditions of the social environment affect an individual therefore all should be taken into account to understand ill mental health (Lotfi, 2019). The biopsychosocial model requires the teamwork of a group of interdisciplinary professionals that includes physicians, nurses, dieticians, psychologists, patient caregivers, religious staff, and social workers (Lotfi, 2019). The physical and biological factors that influence mental health include brain damage, disease processes, genetic factors in abnormal brain development, or imbalances in neurotransmitters or hormones (Black & Hoeft, 2016; Lotfi, 2019). The psychological factors that influence mental health include an individual's life history, and his or her ability to cope with stressors (Black & Hoeft, 2016; Lotfi, 2019). In turn, the social and cultural conditions that influence mental health include considering how people react to illness, how they are treated and the expectations that are created by the culture they belong to (Black & Hoeft, 2016; Lotfi, 2019).

3.4. COMMON MENTAL HEALTH DISORDERS IN SOUTH AFRICA

Mental health diagnoses differ according to their symptomatic features, causes, onset, duration, intensity, and the intervention required for treatment (Barlow & Durand, 2012). Below, the commonly diagnosed mental health disorders are defined. This provides a general understanding of the commonly diagnosed mental health disorders prevalent in South Africa.

3.4.1. Post-Traumatic Stress Disorder

Post-Traumatic Stress Disorder (PTSD) can occur after an individual has experienced or witnessed a traumatic event (Meyer, Matlala & Chigome, 2019). It is categorized as an anxiety disorder with recurring invasive recollections of an overwhelming traumatic event (Meyer, Matlala & Chigome, 2019). Anxiety is defined as a negative mood state that is characterized by unease, fear, worry, and poor perception (Barlow & Durand, 2012).

3.4.2. Generalised Anxiety Disorder

Generalised Anxiety Disorder is characterized by excessive anxiety and worry about activities or events occurring for six months or longer (Meyer, Matlala & Chigome,

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2019). This disorder may be associated with Post-traumatic Stress Disorder and increased rates of substance abuse (Meyer, Matlala & Chigome, 2019).

3.4.3. Major Depressive Disorder

Major Depressive Disorder is also known as unipolar depression (Meyer, Matlala & Chigome, 2019). Depression has been linked to hereditary factors, changes in neurotransmitters, dopamine, altered endocrine functions, and psychosocial factors. The aforementioned is usually coupled with a form of trauma or stressful life event that serves as a trigger for depression (Barlow & Durand, 2012 ; Meyer, Matlala & Chigome, 2019).

3.4.4. Bipolar Disorder

Bipolar Disorder is a mood disorder characterized by episodes of mania, hypomania, and major depression (Meyer, Matlala & Chigome, 2019). Mood disorders result from a combination of genetic vulnerability and stressful life events or trauma in childhood and adolescent years (Barlow & Durand, 2012). There are two subtypes of Bipolar Disorder. These include Bipolar I and Bipolar II (Meyer, Matlala & Chigome, 2019). Individuals with Bipolar I Disorder experience manic episodes and nearly always experience major depressive and hypomanic episodes (Meyer, Matlala & Chigome, 2019). Bipolar II Disorder is marked by at least one hypomanic episode, one major depressive episode, and the absence of manic episodes (Meyer, Matlala & Chigome, 2019).

3.4.5. Manic Episodes

Manic Episodes involve clinically significant changes in mood, energy, activity, behaviour, sleep, and cognition that range from a few weeks to months (Meyer, Matlala & Chigome, 2019). Manic speech is typically loud, pressured or accelerated and difficult to interrupt. It may be accompanied by jokes, singing, and dramatic signals (Meyer, Matlala & Chigome, 2019). Individuals diagnosed with Manic Episodes are often involved in various high-risk and pleasurable activities including promiscuous sexual activities and dangerous sports (Meyer, Matlala & Chigome, 2019).

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3.4.6. Hypomanic Episodes

Hypomanic Episodes are characterised by changes in mood, energy, activity, behaviour, sleep and cognition that are similar to Manic Episodes but less severe (Meyer, Matlala & Chigome, 2019).

3.5. SOCIAL WORK INTERVENTION IN MENTAL HEALTH

Social work intervention, in mental health, is concerned with increasing the well-being of the individual, solving social problems, achieving social justice, and increasing their welfare level (Lotfi, 2019). It begins with the individual and extends to their family, social networks and society (Lotfi, 2019). One of the key goals of social work intervention in mental health is to facilitate effective communication between the individual, their families and other health care professionals (Gehlert & Browne, 2012; Ornellas, 2014). This further assists the individual in activating different sources to help them fulfil their needs and assist with recovery (Lotfi, 2019). Social workers also obtain, understand and provide mental health related information to their clients Gehlert & Browne, 2012; Ornellas, 2014). This is a service not offered by any other mental health care professional (Gehlert & Browne, 2012; Ornellas, 2014). Below, the varying roles upheld by social workers in mental health intervention is discussed. The roles are discussed in relation to the responsibilities social workers uphold in social work intervention in mental health.

3.5.1. Social work roles in mental health

There are many professional roles in social work. However, only those relevant to social work intervention in mental health are discussed. These include the role of a counsellor, relational role, enabler, mediator, educator and advocate.

3.5.1.1. Counsellor

According to Johnson & Yanca (2010), the traditional role of a social worker in mental health intervention is a counsellor. It is thus the responsibility of the social worker to provide support, care and information to individuals. Gelhert & Browne (2012) agree with the aforementioned and describe the role of the social workers as working with individuals and their families to facilitate effective communication between themselves and the health care professionals.

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3.5.1.2. Relational

Mental health diagnoses are often accompanied by stigma and unfair discrimination. In upholding the relational role, social workers can assist in promoting relationships between the individual, their family and the community (Johnson & Yanca, 2010). The relational role is essential when considering the impact and potential difficulties or strain felt by a family upon receiving a mental health diagnosis (Ornellas, 2014).

3.5.1.3. Enabler

Without information readily available, mental health diagnoses can be stressful for an individual and his or her family. In the enabler role, the social worker assists a client in becoming capable of coping with situations or stressors (Chechak, 2004). The social worker also assists individuals in attaining, understanding and using information to help them fulfil their needs (Lotfi, 2019). The information provided may also assist the individual with their recovery or in managing their mental health diagnosis.

3.5.1.4. Mediator

In upholding the role of a mediator, the social worker assists the individual by providing therapeutic interventions (Glanz, Rimer & Viswanath, 2008; Jamner & Stokols, 2000). This role may also extend to the individual's family in the aim to resolve potential conflicts and therewith improve social support (Chechak, 2004). The mediator role also requires the social worker to remain neutral. This often assists the social worker in developing a more positive physical environment and also increases access to resources for their clients (Glanz, Rimer & Viswanath, 2008; Jamner & Stokols, 2000).

3.5.1.5. Educator

The educator role involves the social workers sharing information and teaching skills to clients and other systems. This role requires the social worker to be a good communicator so that information is shared clearly and is understood by the client (Chechak, 2004). The information shared further assists the individual in activating different sources to help them fulfil their needs and assist with recovery (Lotfi, 2019).

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3.5.1.6. Advocate

The advocate role requires a social worker to step forward and speak on behalf of their clients. It is one of the most important roles a social worker can uphold (Chechak, 2004). According to Glanz, et al., 2008; Jamner & Stokols, 2000, this can include advocating for improved mental health service delivery, legislations and policies that are relevant and beneficial to the treatment of mental health diagnosis. Furthermore, in upholding the role of an advocate, social workers can assist their clients in obtaining services, particularly in situations where they may feel rejected or face challenges in accessing it (Johnson & Yanca, 2010).

3.6. KLEINMAN'S EXPLANATORY MODEL

Below, an overview of Arthur Kleinman's explanatory model is provided to contribute towards an understanding of the theoretical framework that underpins this study. Thereafter, the influence of cultural beliefs on social work intervention in mental health using the explanatory model is discussed. The Explanatory Model (EM) attempts to understand the way people conceptualize their needs or problems. It includes acknowledging an individual's beliefs and behaviours concerning the cause of their need or problem, its course, the symptoms, its timing, the meaning of the need or problem, and the preferred methods of intervention (Abad, 2012; Jacob, 2014; Kleinman, Eisenberg, Good, 1978; Petkari, 2015).

In acknowledging the aforementioned aspects, the explanatory model uses an individual's understanding of his or her need or problem and utilises this to guide intervention (Abad, 2012). Kleinman (1980) developed eight questions that guide intervention that extends from the explanatory model (Awan, Jahangir & Farooq, 2015). These eight questions, include (1) what do you think has caused your problem? (2) why do you think it started and when did it start? (3) what do you think your problem does to you and how does it work? (4) how severe is your problem and will it have a short or long course (5) what kind of treatment do you think you should receive? (6) what are the most important results you hope to receive from the intervention? (7) what are the most important results you hope to receive from intervention (8) and what do you fear most about your problem? (Abad, 2012).

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In using the above questions, the explanatory models contextualize the individual, it describes their reality, their ways of coping, and attempts to make sense of their experiences of their need or problem (Buus, Johannessen & Stage, 2012; Jacob, 2017; Kleinman, 1980). The data gathered through asking the above questions could have multiple and complicated responses and will consist of descriptions about the individual's illness, social values, communication systems, and other forms of knowledge (Awan, Jahangir & Farooq, 2015). In light of the aforementioned, it is well acknowledged that explanatory models are divergent and often contradictory when compared to one another (Jacob, 2014). This is largely because most communities are pluralistic and are guided by varying cultures and cultural beliefs (Jacob, 2017). Petkari (2015) and Salloum & Mezzich (2009) agree that explanatory models are not static but both dynamic and flexible. An individual's explanatory model is greatly influenced by the dynamic interplay of social, religious, educational, and political factors (El-Islam, 2008; Petkari, 2015). Jacob (2017) agrees with the aforementioned and stresses that people opt for explanatory models that are best suited to their social environment and their personality.

Explanatory models, when applied to intervention, do not predict the outcomes for intervention. It merely acknowledges the diversity between individuals and utilizes this to best assist an individual in overcoming or coping with their identified need or problem (Jacob, 2017). In turn, utilizing an individual's explanatory model in intervention ensures that intervention is offered in the individual's contextual framework. This further prevents miscommunication because explanatory models assist in clarifying an individual's expectations of intervention (Abad, 2012; Jacob, 2014; Winkelman, 2009). In the context of South Africa, a large proportion of the population hold traditional explanatory models for their needs (Petersen & Lund, 2011). In turn indigenous knowledge, which is elicited through the explanatory model, is often considered as legitimate knowledge in problem-solving and assisting with an individual's need (Zimba, 2020).

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3.6.1. The influence of cultural beliefs on social work intervention in mental health using the explanatory model

It was well acknowledged throughout chapters two and three of this study that cultural beliefs influence both social work intervention and mental health. The dismissal of cultural beliefs in both social work intervention and mental health has dire consequences for the individual. This is largely because cultural beliefs influence how mental health is defined, how it is manifested, and play a role in selecting intervention that is most appropriate to the individual (Bassett, 2011; Jacob, 2014; Kleinman, 1980, Petkari, 2015). In turn, if social work intervention is not guided by what is considered as most appropriate to the individual, the effectiveness of the intervention may be compromised (Jacob, 2014). It is well noted that communities are pluralistic and uphold a wide range of cultural beliefs about mental health (Jacob, 2017). Thus, social work intervention in mental health involves multiple interactions of cultures and frames of reference (Awan, Jahangir & Farooq, 2012; Bassett, 2011). This requires social workers to educate themselves about cultural beliefs and match, negotiate, and integrate interventions that best suit their client systems (Jacob, 2014).

When confronted with this, it may be overwhelming to social workers and in turn, also negatively affect intervention. To acquire a balanced understanding of the influence of cultural beliefs, social workers can call on the assistance that Arthur Kleinman's explanatory model (1980a, 1980b) provides. The application of Arthur Kleinman's explanatory model (1980a, 1980b) in social work intervention places the individual at the centre of the intervention and asks individuals to explain their illness or suffering, why they think it is occurring, how their social group understands or explains it, and their standard approaches to care (Hilty, 2015). It elicits the culturally-based explanations for the cause and expected intervention for mental health (Bassett, 2011; Jacob, 2017; Kleinman, 1980; Petkari, 2015). When applied to intervention, the explanatory model promotes sensitivity and allows for the exploration of an individual's beliefs about their need or problem (Buus, Johannessen & Stage, 2012). It also assists in developing awareness, sensitivity to cultural differences, and cultural dynamics in intervention (Abad, 2012; Bassett, 2011; Jacob, 2017). Using the explanatory model, as the theoretical framework for social work intervention in mental health, helps the social worker understand that mental health is subjective to the cultural beliefs of an

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individual (Awan, Jahangir & Farooq, 2015). In acknowledging explanatory models in social work intervention in mental health, social workers can improve and personalise intervention to the individual and his or her cultural beliefs.

3.7. CONCLUSION

This chapter stressed that mental health is greatly influenced by biological, psychological, social, and cultural factors. The influence of each of these aspects was reinforced through the varying approaches to mental health that considers the role of biological, social, and psychological aspects in both the diagnosis and treatment of mental health. Furthermore, this chapter discussed the common mental health disorders prevalent in the South African context. This painted an image of the challenges faced by those diagnosed and receiving assistance. A social workers' role in mental health service delivery was also elaborated on in this chapter. These roles are significant and extend great value to varying client systems, their family and the community. This chapter also stressed the great influence cultural beliefs have on mental health and the social work intervention offered in mental health. A great emphasis was placed on the need to deliver intervention, in mental health, that acknowledges cultural beliefs. This chapter suggested that Arthur Kleinman's Explanatory Model was one way in which this could be done. As a result, Arthur Kleinman's Explanatory Model was also discussed and explored in this chapter. A great emphasis was placed on how Kleinman's Explanatory Model responds to the mental health needs of individuals by acknowledging the great influence cultural beliefs have on mental health. In turn, this can be used to deliver the most appropriate and preferred methods of intervention to individuals.

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CHAPTER FOUR:

VIEWS OF FRONTLINE SOCIAL WORKERS ON THE INFLUENCE OF CULTURAL BELIEFS ON SOCIAL WORK INTERVENTION IN MENTAL HEALTH

4.1. INTRODUCTION

This chapter pertains to the third objective of this study. Thus, it presents the empirical investigation of the influence of cultural beliefs on social work intervention in mental health, as viewed by frontline social workers. This chapter is presented in two sections, namely section A and section B. Section A provides a concrete reflection of the research methodology utilized and section B highlights the identifying characteristics of the participants, as well as the analysis of the data collected. This section further includes the themes and subthemes that were identified through the analysis of the data collected from the participants.

Chapter one provided a literature background on the research topic and subsequently established a goal for the research study. The goal for this study was to gain an understanding of the influence of cultural beliefs on social work intervention in mental health. Chapter two presented further information relating to the background of study and provided a conceptual theoretical framework for culture, cultural beliefs and social work intervention. Furthermore, it provided an overview of culture, conceptualized cultural beliefs and described its influence on social work intervention. Chapter three provided further insight into the research topic by providing a critical analysis of the influence of cultural beliefs on social intervention in mental health, using Kleinman's explanatory model. It conceptualized mental health and thereafter expressed the defining characteristics of the theoretical framework for this study, Kleinman's explanatory model. Chapter three was concluded by discussing the value the inclusion of cultural beliefs has on social work intervention in mental health alongside the application of Kleinman's explanatory model. This chapter presents the empirical findings in relation to the influence of cultural beliefs on social work intervention in mental health, as viewed by frontline social workers. The findings are presented in the form of graphs, tables, themes, sub-themes and categories, where applicable.

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SECTION A

This section provides a concrete reflection of the research methodology utilized in this study. An analytical reflection and an overview of the research methodology is presented. For a more detailed discussion of the research methodology used, refer to chapter one of this study.

4.2. RESEARCH METHODOLOGY

This section reflects on the various aspects of the research methodology utilized in this study. More specifically, it discusses the research approach, research design, sampling method, methods of data collection and the data analysis.

4.2.1. Research Approach

This approach was selected because the study aimed to gain an understanding of the influence of cultural beliefs on social work intervention in mental health, as viewed by frontline social workers. The use of the qualitative approach therefore assisted in attaining in-depth descriptions from the participants about the influence of cultural beliefs on social work intervention in mental health. The application of the qualitative research approach was successful as large, descriptive volumes of data were obtained from the participants during the empirical investigation

Furthermore, the researcher also engaged in deductive logic of reasoning. This involved the researcher conducting a literature study (as presented in chapter two and three of this study) before the empirical study was conducted (Babbie, 2007). In doing this, the researcher gained a broader understanding and improved her knowledge surrounding cultural beliefs, social work intervention, and mental health. Although the research study was largely deductive, the researcher also engaged in inductive reasoning. The researcher often moved between deductive and inductive reasoning throughout and beyond the empirical study. This often required the researcher to revisit literature after the empirical study was concluded as the participants identified and elaborated on aspects of cultural beliefs, social work intervention and mental health that were not included in the literature chapters of this study.

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4.2.2. Research Design

This study utilised both exploratory and descriptive research designs. The exploratory research design added great value to this study as it allowed this study to gain insights into the influence of cultural beliefs on social work intervention in mental health. Furthermore, it assisted in attaining in-depth descriptions of the participants' views on each of the phenomena. Also, the descriptive research design was useful in gaining insights into the views of the participants surrounding the influence of cultural beliefs on social work intervention in mental health. Consequently, both the exploratory and descriptive research designs were used to gain as much information as possible from the participants and as a result, in-depth descriptive narratives were obtained from the participants. Thus, in summation, the application of both the exploratory and descriptive research design were successful and no challenges were experienced in its application.

4.2.3. Sampling methods

Purposive sampling was used to recruit participants for this study. The criteria for the inclusion of participants were the following:

- A registered social worker with the South African Council of Social Service Professionals (SACSSP).
- A social worker who is employed in the field of mental health in the Western Cape.
- A social worker who has at least two years' experience in delivering the intervention in the field of mental health.
- Proficient in the English language.

Furthermore, it is important to note that social workers, belonging to varying cultures, upholding varying cultural beliefs, were participants of this study as the study did not focus on a particular culture or cultural practice. The participants were sourced from the researcher's professional network. This included social workers who the researcher had developed relationships with during her professional career as a social worker and through her academic career as a social work student. Each of the participants were formally invited to participate in this study via electronic mail. Following this, the researcher sent the participants an informed consent form, attached

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as Annexure A. The participants were asked to sign the informed consent form, and this ensured that they were aware of all the ethical considerations associated with the study which included their right to refuse to answer and withdraw at any time without any consequences. Furthermore, the informed consent form also included the purpose, benefits, and the potential risks associated with the research study. All participants were interviewed during their personal time and in their personal capacity and not within their office or practice hours of their respective organizations thus, it was not necessary to obtain clearance from the participant's respective organization. The duration of the interviews spanned across twenty to forty minutes and the interviews were conducted 1st of February until the 31st of March 2021 in Cape Town,

In total, fifteen participants were interviewed. Although twenty participants were recruited, data saturation was reached after the fifteenth interview was concluded. Data saturation occurs when no new data emerges, no new themes are identified and the ability to replicate the study has been achieved (Fusch & Ness, 2015). Staller (2021) aligns with the aforementioned and confirms that saturation is when collecting more empirical evidence does not produce any additional theoretical insights. It is the point in the analysis when the researcher does not see any new information in the data. Thus, no codes, themes or theory emerge (Guetterman, 2014). The minimum, acceptable size of a sample for a qualitative study is between fifteen and twenty participants (Given, 2008; Scott & Garner, 2013). Thus, the study's sample size of fifteen participants was sufficient.

4.2.4. Data collection

Although qualitative interviews are traditionally conducted on a face-to-face basis, one-on-one telephonic interviews were conducted with the participants. Face-to-face interviews were no longer available as this study has not been acknowledged by the South African Government, under the Presidential Regulations, as an essential service related to the COVID-19 pandemic. A semi-structured interview schedule, attached as Annexure B, was used to guide the interview between the researcher and the respective participant. The combination of both open-ended and closed questions allowed the researcher to probe information from the participants and assisted the researcher in developing an in-depth understanding of participant's views. The use of

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one-on-one telephone interviews for this study was well suited. It met the strengths of the researcher and participants. Furthermore, the use of the telephone is now more prominent in social work practice as the World Health Organisation advocated for social distancing measures to be implemented globally to help deter the vast rate at which the COVID-19 virus was spreading (WHO, 2020).

Before conducting the interviews with participants, the researcher asked all participants whether they would be comfortable with the researcher recording the interviews. It was stressed to the participants that the researcher would only record the interviews so that it could be transcribed after the interviews were concluded. All fifteen participants consented to this, and the researcher used a mobile application called Cube ACR to record the one-on-one telephonic interviews. The use of this mobile application ensured that all recordings were saved on the researcher's password-protected mobile device and was later transferred to the cloud service, Microsoft OneDrive. This cloud service requires a username and is password-protected thus access to it is controlled and further secured. The interviews were conducted from the 22nd of February 2021 to the 30 of March 2021 and no challenges were experienced in conducting or recording these interviews.

4.2.5. Data analysis

Data analysis began after all fifteen participants had been interviewed. All data were analysed using thematic analysis. Aligning with the procedure for thematic analysis, a five-step process was conducted. The process included the following: converting all audio-recordings into a written format, generating codes and identifying trends in the data, categorizing the trends found in the data and therewith the identification of themes and subthemes. This assisted in directing the researcher's thoughts towards the data and thereafter producing the final report.

Furthermore, a **denaturalization process** was used during the initial phase of the thematic analysis process, namely during the conversion of the auto-recordings into a written format. This promoted a focus on the content rather than the way the words were said. Practically, as guided by Oliver, Serovich & Mason (2005), this resulted in the researcher omitting habitual instances of silences, pauses and stutters. The

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researcher further extended the denaturalization process and corrected grammatical errors made by the participants. All edits made by the researcher, as per the denaturalization process, did not take away from what was meant by the participant's responses.

The researcher also conducted **member checking** with the participants. The researcher did this by selecting three transcripts, at random, and returned these to the participants via electronic mail. The participants were then asked to verify the accuracy of the transcripts. Also, the researcher remained in close contact with the participants throughout the process of data analysis to ensure that the researcher's findings aligned with the views expressed by the participants. The researcher further engaged in **reflexivity** throughout the process of data analysis. To uphold reflexivity, the researcher kept a journal where she recorded her thoughts, feelings, uncertainties, values, beliefs, assumptions and biases that rose from the process of data analysis. This helped the researcher to remain aware of her biases and maintain objectivity. The researcher also compiled a reflexivity report, attached as Annexure E, where she further expressed her entanglements in the research process.

SECTION B

This section describes the identifying characteristics of the research participants that were examined during the empirical study. Furthermore, it presents the themes and sub-themes that were identified through analysis of the data collected from the participants. The participant's narratives will be presented in a tabular summary and in *italics* for the reader's ease.

4.3. PARTICIPANT PARTICULARS

This section describes the individual characteristics of the research participants in terms of their work context, their years of service as a social work professional and their years of practice in the field of mental health. In providing individual profiles the researcher aims to create a comprehensive context for each of the participants. This is relevant as the participant's individual profiles may be helpful in interpreting the contexts of their narratives. The analysis of the data attained is presented further in this chapter.

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4.3.1. Work contexts

Acknowledging and therewith analysing the work contexts of the participants is pertinent as it may assist the researcher with the interpretation of the participant's narratives. The work contexts of the participants are presented in a pie chart below.

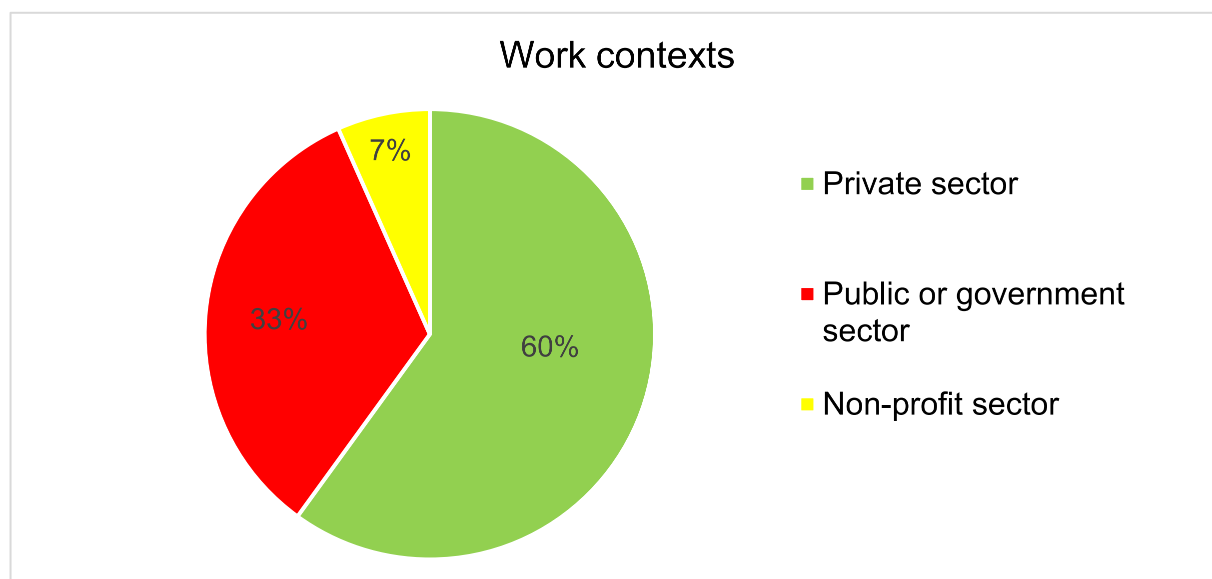

Figure 4.1. Work contexts of the participants. (N=15)

Fifteen participants (100%) were interviewed by the researcher. Of the fifteen participants, nine (60%) are employed in the private sector, five (33%) are employed in the public or government sector and only one of participants (7%) is employed in the non-profit sector. As further illustrated in Figure 4.1., the majority of the participants in this study are employed in the private sector, with just under half of the participants (40%) are employed in both the public or government sector and the non-profit sector.

The non-profit or private sector, where the majority of the participants are employed, is further divided into a profitable and non-profitable sector (Patel, 2015). The non-profitable sector includes organisations that rely on the government for funding and usually operate in strict bureaucratic procedures and systems. Social workers thus have limited autonomy and minimal flexibility in programme development. This is largely because programme development depends on national norms and standards (Patel, 2015). The private sector is comprised of organisations that render social work services for profit. These services are offered to individuals, families, groups and

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communities or organisations at a cost (South Africa Association for Social Workers in Private Practice, 2019). Social workers, who are employed in the private sector as private practitioners, must comply with regulatory frameworks, norms, standards and the conditions of their registration as per the Council of Social Service Professions (Lord & Iudice, 2012).

4.3.2. Length of time as a social worker

The length of time, in years, that the participants have been social workers is presented in a bar graph below.

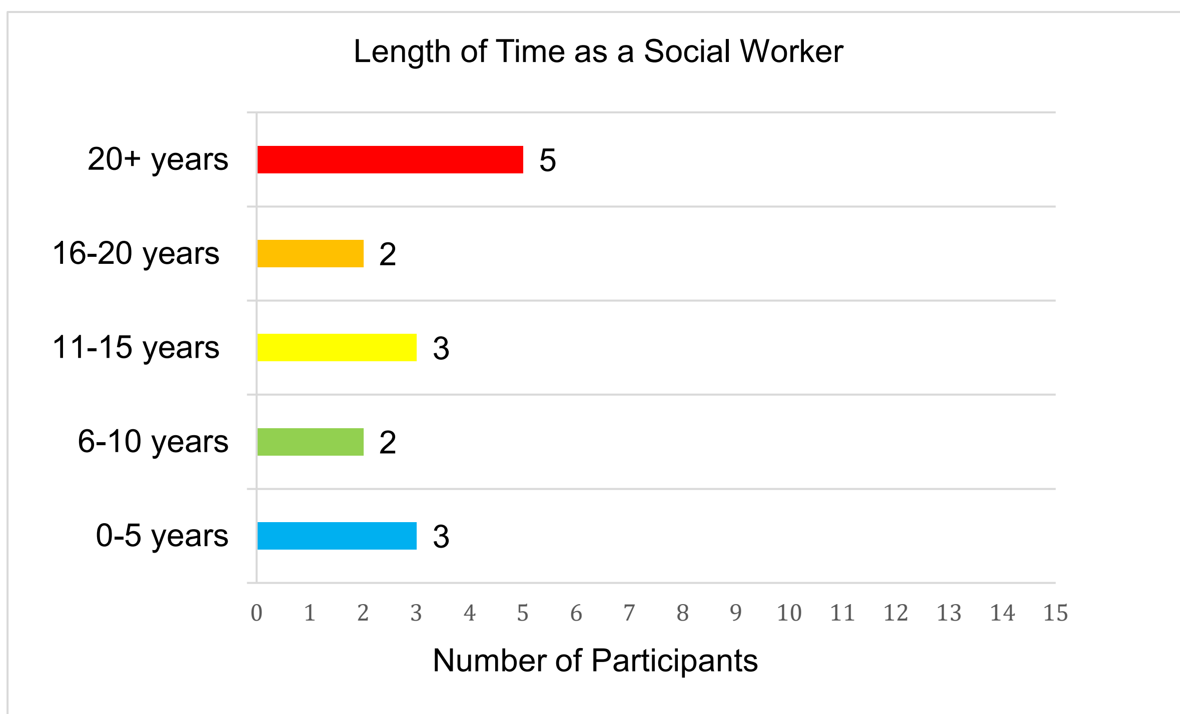

Figure 4.2. Length of time as a social worker (N=15).

As illustrated in the bar graph above (Figure 4.2.), five participants (33%) have 20 or more years of experience as a social worker. This group is the largest among all the participants. The second-largest group are those participants with between eleven and 15 years' experience and those with between zero and five years' experience. Three participants (20%) fall into each of these categories thus it can be stated that 20% of participants have between 11 and 15 years' experience and 20% of the participants have between zero and five years' experience. The least prevalent group are those participants who have between 16 and 20 years' experience and those who have

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between six and ten years' experience. Two participants (13%) fall into each of these categories thus it can be stated that 13% of the participants have 6 to 10 years' experience as a social worker and 13% have between 16 and 20 years' experience. When considering the aforementioned, most of the participants can be classified as being largely experienced, with their experience extending from 20 years or more. According to Earle (2008a), the second-largest age group of social workers, in the context of South Africa, are those between the ages of 50-54 years. The largest group are those who are between the ages of 25 and 29 years of age (Earle, 2008a).

Although these findings do not exactly correlate with the findings of this study, it must be acknowledged that participants between zero and ten years and 20 years or more are those that account for the majority of the participants for this study. The findings also show a lack of social workers who are medium-experienced, with experience ranging from six to ten years. Furthermore, it also indicates that there could be a smaller number of more-experienced social workers in the years to come, should the largely experienced social workers retire. This potential shortage of social workers in the near future may hamper the ability of varying organisations or sectors to meet the increasing demands for social services. It also further exposes South Africa's most vulnerable group to a greater risk of harm (Skhosana, 2020).

4.3.3. Length of time practicing in the field of mental health

The criteria of inclusion for this study required social workers to have at least two years' experience in the field of mental health, thus it can be stated that all the participants of this study have at least two years' experience in the field of mental health. However, a more detailed representation of the participant's length of time practicing in the field of mental health is presented in a bar graph below.

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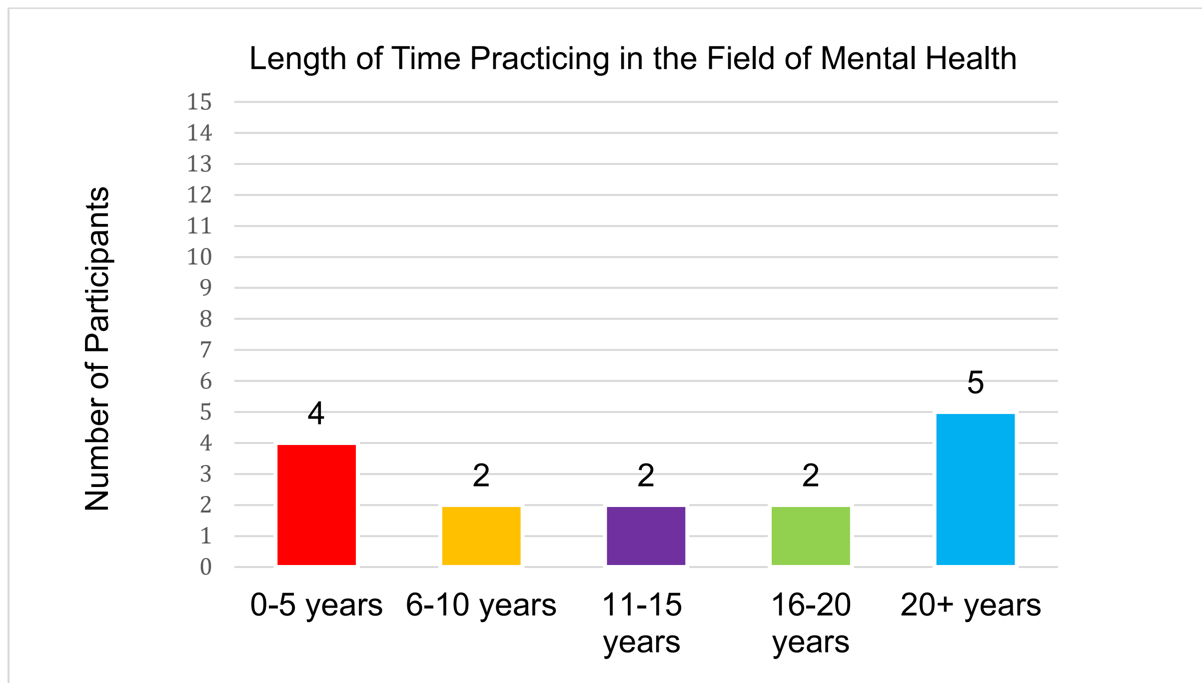

Figure 4.3. Length of time practicing in the field of mental health (N=15)

As illustrated in the bar graph above (Figure 4.3), five participants (33%) have 20 years or more experience in the field of mental health. This correlates with the data presented above, in Figure 4.2. In considering this, it can be stated that the majority of the participants in this study have been employed in the field of mental health since the onset of their social work career. In considering the data presented above in Figure 4.3., four participants (27%) have between zero and five years' experience in the field of mental health. This is the second most prevalent group in this study. The least prevalent groups are those participants who have between six and ten years, eleven- and fifteen-years' experience and sixteen and twenty years' experience. Each of the categories have two participants, thus amounting 13% of participants for each of the categories.

In considering the aforementioned, it must be noted that the researcher's experience in the field of mental health correlates with the category of between zero and five experiences. As indicated earlier in this chapter Earle (2008a) confirmed that the largest group of social workers in the South African context are those between the ages of 25 and 29 thus correlating with the data attained and confirming the zero to five years' experience category as prevalent group among social workers. The

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absence of participants in the categories of between six and ten years, eleven and fifteen years' experience and sixteen and twenty years' experience further speaks to the absence of medium-experienced social workers, as identified in Figure 4.2. According to Skhosana (2020) many social workers, after some years of experience, may choose other careers. This is often prompted by the heavy workloads, highly demanding and challenging roles, and responsibilities that social workers are prone to facing.

4.4. THEMES AND SUB-THEMES

A total of three themes, with ten subsequent sub-themes and its categories were identified from the narratives of the participants. Below is a tabulated summary of all the themes, subthemes and categories, as identified by the researcher.

Table 4.1: Themes, subthemes and categories

THEMES	SUBTHEMES	CATEGORIES
1. Understanding Culture	Subtheme 1: Culture	Category 1: Religion
	Subtheme 2: Cultural Beliefs	Category 2: Child-rearing
		Category 3: Guidance
		Category 4: Race
	Subtheme 3: Social work practice	Category 5: Lack of acknowledgement
		Category 6: Ethical practice
	Subtheme 4: Social work intervention	Category 7: Improving the effectiveness
2. Mental health and social work intervention	Subtheme 1; Understanding mental health	Category 1: Integrated approach
		Category 2: Well-being
	Subtheme 2: Social work roles	Category 1: Educator
		Category 2: Advocate
3. Integration of models	Subtheme 1: Kleinman's Explanatory Model	

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	Subtheme 2: Social work intervention	Category 1: Improving intervention
	Subtheme 3: Mental health service delivery	Category 1: Improving service delivery
	Subtheme 4: Social work practice.	Category 1: Workload
		Category 2: Working conditions

The researcher made use of both sub-themes and categories as it provides structure to the participant's narratives and provides a framework for analysis of the data. All data analysis will be done in correlation to literature. The identified themes, sub-themes and its categories will be presented in a tabular summary before it is discussed in detail by the researcher. To promote a sense of uniformity for this section, the researcher will aim to work in a cyclical pattern. In saying this, the questions that the participants were asked are explained before excerpts of the participants' narratives are offered. This is done to show how the participants' narratives help support and describe the themes identified by the researcher. An analysis of the findings is then presented through explaining the links it has with the literature presented throughout the literature review chapters of this study (chapter two and three). Should instances occur where themes are identified that do not coincide with what is identified in the literature review, inductive reasoning is applied by identifying and using new literature. Furthermore, the core ideas of the participant's narratives are presented in order to provide a graphic illustration of both the sub-themes and its categories. This is followed by an explanation of the value it may have against literature.

4.4.1. Theme 1: Understanding Culture

Table 4.2: Theme 1: Understanding Culture

Theme	Subtheme	Categories
1. Understanding culture	Subtheme 1: Culture	Category 1: Religion
	Subtheme 2: Cultural Beliefs	Category 2: Child-rearing
		Category 3: Guidance

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		Category 4: Race
	Subtheme 3: Social work practice	Category 1: Lack of acknowledgement
		Category 2: Professional practice
	Subtheme 4: Social work intervention	Category 3: Improving the effectiveness of Intervention

In this section, participants were asked to define culture, describe their understanding of cultural beliefs, and thereafter express frequently they believed cultural beliefs were acknowledged in social work intervention. Following this, the participants were asked what they believed the influence of cultural beliefs on social work intervention in mental health is. Below, each of these questions is explored in relation to the sub-themes and categories that were identified by the researcher.

Subtheme 1: Culture

The participants were asked to describe culture. Cultural beliefs are a component of culture thus it was important that the researcher attain the participant's understanding of culture before following with the questions surrounding cultural beliefs. According to Alvarez-Hernandez & Choi (2017) culture is well-recognised as a complex phenomenon, with an array of meanings thus the researcher expected a large variety of definitions from the participants. However, only one category emerged from the narratives. This category is further discussed below.

Category 1: Religion

The narratives of the respective participants are presented below in Table 4.3.1.

Table 4.2.1: Participants Narratives

Participant 3:	*"…it's a combination of your personal beliefs, <u>your religious beliefs</u>, historical background…"*
Participant 6:	*"…it is the tradition… <u>religion</u> and that you were raised in…"*

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The narratives presented above both make reference to religion thus indicating that the participants understand culture in relation to or extending from religion. In considering the participants' narratives, Fernando (2014) confirms that culture to a large extent determines an individual's religious systems. However, it is important to note that culture does not extend from religion, it is religion that may extend from culture (Fernando, 2014). In alignment with the aforementioned, Hatala (2012) and Rugman (2013) emphasize that culture influences our beliefs thus including our religious beliefs. It can thus be stated that religion and culture exist in close relation to one another. The study of both culture and religion requires the other in order to develop in-depth understanding of the two concepts (Beyers, 2017). According to Figl (2003), there are many elements that are considered part of religion that are also connected to cultural elements. Thus, the intertwined relation of religion and culture cannot be denied or ignored and culture and religion must be viewed as relatives (Figl, 2003; Beyers, 2017).

Subtheme 2: Cultural Beliefs

Participants were asked to express their understanding of cultural beliefs. It was essential that the researcher view how the participants conceptualise cultural beliefs as the study aims to investigate the influence of cultural beliefs on social work intervention in mental health. The participants' narratives are presented below in Table 4.3.2 and table 4.3.3. Three categories emerged from the narratives. Each of these categories is discussed below.

Table 4.2.2: Participants' Narratives

Participant 2:	*"…I think it's a system that you sort of, a belief system that you have grown up with that sort of ingrained in you and that shapes how you work, how you act, knowingly and unknowingly."*
Participant 5:	*"Cultural beliefs I see that it's sometimes the way that we are grown up, the right, the wrongs that we are taught, like you don't work on a Sunday, you know that was the way we were brought up and that was sort of a cultural belief."*

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Category 1: Child-rearing

Each of the narratives presented above, make reference to cultural beliefs as being engrained in an individual or used to support upbringing. Aligning with the participants' narratives, Barrera et al. (2017) confirm that cultural beliefs are transmitted from elders to children. Through child-rearing, cultural beliefs guide an individual's actions, their behaviours and determine how they perceive and feel (Kaur & Kaur, 2016; Spencer-Oatey, 2012).

Category 2: Guidance

Each of the narratives express an understanding of cultural beliefs as an embedded ideology that guides and shapes an individual's interactions and in turn, their actions. Kaur & Kaur (2016) and Singer et al., (2016) align with the aforementioned and confirm that cultural beliefs help individuals to make sense of their world by providing a sense of safety, well-being, integrity and belonging. In considering the aforementioned and aligning with the participants narratives, cultural beliefs form a part of an individual's every encounter and every interaction (Bassett, 2011).

Category 3: Race

The narratives presented below in table 4.3.3. elaborate on cultural beliefs in relation to and associated with race. However, according to Leighton & Hughes (1961), Fernando (2010), and Rugman (2013), culture is more complex when compared to race. When placed alongside one another, cultural beliefs and race have two greatly different definitions. As further elaborated on in chapter two of this study, race refers only to the differing biological characteristics among individuals such as skin colour, eye colour and shape and hair type whereas cultural beliefs refer to an awareness or understanding of one's culture (Leighton & Hughes, 1961; Fernando, 2010; Rugman, 2013). Although Rugman (2013) confirms that forms of racism have emerged in relation to culture, it is still very clear that these two concepts are vastly different when compared to one another.

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Table 4.2.3: Participants' Narratives

Participant 1:	*So… from working with adolescents particularly, there's a mixture of our black kids, that we see, specifically the Xhosa culture, that I have worked with and then there's a slightly different kind of thing [cultural beliefs] with the coloured and white kids that they come with*
Participant 7:	*My clients are mostly either white or coloured but not exclusively, but the only reason for that is the geographical area which my practice is in so I don't have to deal with it [cultural beliefs] on a daily basis…*

Subtheme 3: Social work practice

Participants were asked what, in their personal opinion, how frequently, they believed, cultural beliefs were acknowledged in social work intervention. The participants expressed varying views on the inclusions of cultural beliefs in social work intervention, thus two categories emerged. Each of these categories is discussed below.

Category 1: Lack of acknowledgement

The narratives presented below in Table 4.3.3 highlight that social workers may not be acknowledging a client's culture or their cultural beliefs in social work intervention. The narratives emphasize that social workers may not always consider cultural beliefs in intervention, that not enough attention is given to it, and that the acknowledgment of cultural beliefs, in social work intervention, is a neglected area. This is concerning as social work is often referred to as being moulded to assist individuals of varying cultures (Rankopo, & Osei-Hwedie, 2011).

Furthermore, it paints a concerning image for successful social work intervention in the context of South Africa. This is largely because social work intervention, according to Asmal, et al., (2011) and Shokane & Masoga (2018), is only successful when it accepts both culture and diversity. In acknowledging an individual's cultural context social workers accept that people react differently to social problems (Lotfi, 2019). It also implies that social workers acknowledge that people prefer to be acknowledged or treated in a culturally acceptable way and that they have expectations that are

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strongly influenced by their cultural beliefs. In the absence of afore mentioned in intervention, social workers are promoting discrimination (Hatala, 2012). As discussed in chapter two of this study, in promoting discrimination, social workers are diminishing social work values and therewith failing to recognize and value the worth of individuals (Ugiagbe, 2015).

Table 4.2.4: Participants' Narratives

Participant 5:	*"I don't think it is always looked at or assessed and I think it plays an important role to be very aware of this."*
Participant 9:	*"I think it should be taken into consideration all of the time, I do think, however, you know that even now where I feel that this is part of training, we are not necessarily giving enough attention to it".*
Participant 12:	*"Well I would say, with my experience that, I would say it is a neglected area. I would say that, not necessarily because it is neglected in a deliberate sense or conscious sense but because I think that again, it is kind of… it wouldn't be on top of the list of what's important when maybe you know, assessing somebody for services".*

Category 2: Professional practice

The narratives presented below in Table 4.3.4 identify that the ability to acknowledge cultural beliefs in social work intervention, is not an explicit practise but rather one that is influenced by the professional practise of individual social workers. This is concerning because it can thus be assumed that social work intervention, delivered to many client systems, may be inconsistent with their cultural beliefs.

Table 4.2.5: Participants' Narratives

Participant 1:	*"Not often enough. I think it also depends, the older social workers might struggle a little bit more, because I am one of them. I think a lot of the older folk actually just don't realise it…don't acknowledge it".*

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Participant 4:	*"So when I do go into my reports…when it comes to acknowledging culture in intervention I don't think it is acknowledged as culture but rather acknowledged as their normal and then tuning into that and then setting the pace from there, so depending on how effective I am as a social worker that would then impact the way culture comes into play into the intervention strategy…"*
Participant 8:	*"I wanted to host a child from a children's home so the social worker had to assess us…* she [social worker] *asked something about cultural beliefs, culture and religion… so we said we are not practising Christians but we believe in Christian values and then she wrote the report and she said that we were regular church goers and then I objected because it wasn't true and I didn't want to be presented in a way that wasn't true so I tried to get the report changed but it was to no avail. I don't think they care anymore".*

This further implies that social workers may be failing to acknowledge and accept the diversity of their client systems thus contradicting the Global Definition of Social Work. As highlighted in chapter one of this study, The Global Definition of Social Work that stresses that intervention offered by social workers should be guided by, amongst other things, by the respect for diversities (International Federation of Social Work and International Association of Schools of Social Work, 2014). Jacob (2014) emphasises that social workers should educate themselves about cultural beliefs in order to match, negotiate, and integrate interventions that best suit their clients. This is largely because intervention often involves a large variety of cultures and frames of references that stem from both the social worker and his or her client system (Awan, et al. 2012; Bassett, 2011). However, when considering the narratives presented, this may not be practiced by social workers. As presented above, participant 1 makes references to the age of social workers and emphasises that older social workers may struggle with acknowledging cultural beliefs in social work intervention whereas participant 4 identifies the effectiveness of social workers and how this may impact acknowledging cultural beliefs in social worker intervention. Furthermore, as identified

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by participant 8, it appears that social workers may also not understand culture or cultural beliefs and what it entails in the context of social work intervention. It is clear, from the narrative, that cultural beliefs were associated with religion. This is also identified in subtheme 4.4.1.1 where culture was described in relation to one's religion. All four of these narratives are concerning as social workers hold an ethical and professional responsibility to continually update their professional knowledge and skills for the end benefit of the clients and communities that they serve (South African Council for Social Service Professions, 2019).

Subtheme 3: Social work intervention

Participants were asked to describe, in their view, the influence of cultural beliefs on social work intervention in mental health. The focus of this question was on the cultural beliefs of the service users rather than the cultural beliefs of the social worker. The participants' narratives are further discussed in the categories presented below.

Category 1: Improving the effectiveness

The participant's narratives, presented below in table 4.3.5 , all agree that the influence of cultural beliefs on social work intervention in mental health is great and when acknowledged, it could improve intervention outcomes.

Table 4.2.6: Participants' Narratives

Participant 5:	*"…it is important to take cognizance of it, for them to understand that.. so, we can really <u>render a service to the client that fits into where they are and what their cultural beliefs are</u>."*
Participant 13:	*"I think it's important because we make up our, our cultural beliefs make up who we are so to <u>dismiss it, is to dismiss a part of the individual so for me, it's important</u>…"*

As further emphasized by the narratives presented above, in acknowledging an individual's cultural beliefs, intervention that is relevant and cognisant of the individual's culture will be implemented by the social worker. According to Abdullah, (2015) and Mayer & Viviers (2015), this not only benefits the individual but also promotes an enhanced understanding between the social worker and the client, plays

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a role in building rapport, trust and encourages compliance to the objectives of intervention. As emphasised by participant 13 in their narrative presented above, cultural beliefs "make up who were are" as individuals, thus in acknowledging it in intervention, it allows the individual to express and include local systems of knowledge, concepts, rules, and practices that are acceptable to individuals (Schiller & De Wet, 2019). This individualises intervention and makes it unique to the individual's circumstances, their cultural beliefs, and their needs. This aligns with the narratives expressed by participant 5 (as presented above) and the ability to render intervention that fits into where the client is. In delivering intervention that is unique to an individual and their cultural beliefs, social workers not only accept the large influence cultural beliefs has on an individual's life but also acknowledge that people, who belong to different cultures, and uphold different cultural beliefs, experience, understand, respond to and behave differently in similar situations (Zoabi & Savaya, 2012).

4.4.1. Theme 2: Mental health and social work intervention

Table 4.3: Theme 2: Mental health and social work intervention

Theme	Subtheme	Categories
2. Mental health and social work intervention	Subtheme 1: Understanding mental health	Category 1: Integrated approach
		Category 2: Well-being
	Subtheme 2: Social work roles	Category 1: Educator
		Category 2: Advocate

In this section, participants were asked what their understanding of mental health is as well as what they believed the role of social workers hold in mental health service delivery. Below, the participant's responses are presented in alignment with the sub-themes and categories that were identified by the researcher.

Subtheme 1: Understanding mental health

Participants were asked to describe their understanding of mental health. Varying responses were received. However, two core tenets were identified in the narratives thus two categories emerged. These are further discussed below.

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Table 4.3.1: Participants' Narratives

Participant 5:	*Mental health I see as not only as the mental part but it's also actually our whole circumstance, our whole life, from your physical health, your social environment, your relationships. The whole holistic approach to how you are, actually how you will be mentally healthy so that you will be able to function and make a contribution to your community."*

Category 1: Integrated approach

As identified in the narratives, presented above, each of the participants describe mental health as being a part of an individual's holistic health thus considering their emotional and physical well-being. These narratives closely align with the biopsychosocial approach to mental health, as described in chapter three of this study. In identifying the approach to mental health that best aligns with the narratives, the researcher gained a greater understanding of the way participants may deliver intervention in mental health. The biopsychosocial approach to mental health assumes that physical, psychological and the conditions of a social environment affects an individual thus all aspects should be taken into consideration in understanding mental health. (Lotfi, 2019).

Category 2: Well-being

As presented in table 4.3.2. below, the participants' narratives clearly make reference to well-being when explaining their understanding of mental health. Furthermore, participant 6 highlighted viewing mental health on a continuum of both languishing and flourishing. This aligns with Galderisi, Heinz, Kastrup, Beezhold, & Sartorius (2015) definition for mental health, as explained in chapter three of this study. In their definition, Galderisi, Heinz, Kastrup, Beezhold, & Sartorius (2015) also define mental health in relation to an equilibrium. It can thus be stated that an individual in equilibrium is balanced and thus may not have mental health needs. The same cannot be said for these individuals who are either languishing or flourishing. Moreover, participant 6 discussed their understanding of mental health in relation to the well-being perspective. According to Haworth and Hart (2007), well-being is intimately linked to the physical, cultural and technological environments we reside in. As a result, service

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delivery in mental health and therewith well-being requires recognition of diversity and socio-economic inequalities in society (Haworth & Hart, 2007). This is replicable of the social approach to mental health that was discussed in chapter three of this study.

Table 4.3.2: Participants' Narratives

Participant 3:	*My understanding of mental health is the well-being of the individual. All of us have strengths and positive aptitudes so for me, I see well-being in a logical sense.*
Participant 6:	*Mental health, for me, it's on a continuum and if you look at the well-being perspective. I think academically and I do believe in it, it is on the continuum of where you are languishing and flourishing on the other side.*

Subtheme 2: Social work roles

The participants were asked, in their personal opinion, what the role of social workers are in mental health service delivery. Two roles, namely the role of an educator and the role of an advocate, were identified by the participants, through their narratives. In turn, this formed the two categories that were identified by the researcher. Each of these categories as well as the participants' narratives are elaborated on below.

Category 1: Educator

The narratives presented below in table 4.4.2. identify the social worker's role in mental health service delivery as that of an educator.

Table 4.3.3: Participants' Narratives

Participant 3:	*"… the social worker is really the person who is making sure that all the lines are being pulled together in terms of the service that needs to be delivered to the client at the end of the day so that it makes sense."*
Participant 4:	*"… the role of the social worker in delivering mental health would be to focus on self-awareness so as to increase the awareness of clients…"*

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As discussed in chapter three of study, the educator role involves sharing information and teaching skills to clients, groups and communities (Chechak, 2004) As presented below, the participants clearly identify the social worker's role as imparting information and through this creating awareness for and among their client systems and their communities. This is imperative as Jacob & Coetzee (2018) confirmed that sharing information and creating awareness has a significant impact on health at both the individual and population level.

Category 2: Advocate

Additionally, the narratives presented below in table 4.4.3., identify the role of a social worker in mental health service delivery as that of an advocate.

Table 4.3.4: Participants' Narratives

Participant 5:	*"I think it's an important part where we can be advocates and fight for better mental health services as well as for people who cannot do these kinds of things."*
Participant 7:	*"…to function as a triage function and make appropriate referrals to the appropriate mental health professionals like psychiatrists, psychologists, occupational therapists where required."*
Participant 8:	*"I think the role of the social worker is to advocate for the person's rights and human rights and one of those is good mental health so if you don't have it, to me, it's the thing to advocate for, because if you don't have that, you don't have anything".*

The advocate role involves stepping forward and speaking on behalf of their client, groups and within their communities (Chechak, 2004). As indicated in the narratives presented above, particularly that of participants 5 and 8, an emphasis is placed on a social worker's ability to advocate for better mental health services and human rights, As highlighted in chapter three of this study and aligning with the participants narratives, Glanz, et al., 2000) agree that one of tasks of the advocate role is advocating for improved mental health service delivery, legislations and policies that are relevant and beneficial to the treatment. Furthermore, as identified by participant

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7, in the narratives presented above, in upholding the role of an advocate, social workers can also assist their clients in obtaining services through ensuring that the appropriate referrals are made on their behalf (Johnson & Yanca, 2010). This further promotes access to services.

4.4.1. Theme 3: Integration of models

Table 4.4: Theme 3: Integration of models

Theme	Subthemes	Categories
3. Integration of models	Subtheme 1 :Kleinman's Explanatory Model	
	Subtheme 2: Social work intervention	Category 1: Principle of acceptance
		Category 2: Principle of individualisation
	Subtheme 3: Mental health service delivery	Category 1: Improving service delivery.
	Subtheme 4: Social work practice	Category 1: Workload

4.4.2. Theme 3: Integration of models

The participants were asked to express their understanding of Kleinman's Explanatory Model, how useful they believed Kleinman's Explanatory Model would be in social work intervention, whether it would be a useful model in mental health service delivery and how often they believed social workers deliver intervention that aligned with Kleinman's Explanatory Model.

Sub-theme 1: Kleinman's Explanatory Model

Participants were asked whether they had any understanding or knowledge surrounding Kleinman's Explanatory Model. However, none of the participants had any understanding of Kleinman's Explanatory Model. The researcher then explained the model to the participants and asked that they use the researcher's explanation as a point of departure for the questions that followed. It is important to note that the

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researcher's explanation of Kleinman's Explanatory Model was prepared beforehand and it was merely recited to each of the participants. This ensured that the participants each received the same explanation.

Subtheme 2: Social Work Intervention

Participants were asked, in their personal opinion, how useful they believed Kleinman's Explanatory model would be in social work intervention. All participants agreed that it would be a useful to social work intervention. However, their reasoning for confirming the useability of Kleinman's Explanatory Model varied. Two categories emerged from participants' narratives. Each of these categories is explored below.

Table 4.4.1: Participants' Narratives

Participant 4:	*"I definitely agree that the client should define the need and use that as a form of strategizing but more importantly it will also allow me as a practitioner to view what is important to them and how they view themselves so it would allow me to provide a space that speaks more to the client's level"*

Category 1: Principle of Acceptance

Each of the narratives presented above in table 4.4.1., emphasise that clients should be allowed to define their need or problem. Thereafter, the social worker should use what the client has described to plan for intervention. This acknowledgment of the client's views aligns with the social work principle of acceptance. In using the principle of acceptance, social workers treat their clients in a humane manner and afford them both dignity and worth (Sajid, 2012). Furthermore, it also advocates admissibility of the client irrespective of their culture (Uzuegbu, et al., 2017). In aligning with participants 4's narratives, social workers convey the principle of acceptance through listening receptively and acknowledging their client's points of view. This further promotes empathy, warmth and support, so as to create an enabling environment that will invariably help the client share information openly (Uzuegbu, et al., 2017)

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Category 2: Principle of Individualisation

As presented above, each of the narratives identify the value of allowing the client to lead intervention by describing their need or problem. This aligns with the social work principle of individualisation. When social workers apply the principle of individualisation in intervention, they recognize and appreciate the client's unique qualities and individual differences (Sajid, 2012). This enables social workers to deliver intervention that is individualised and unique to the individual it assists. It further allows the social worker to be sensitive to each individual's unique history, characteristics and situation thus including their culture (Uzuegbu, et al., 2017). Furthermore, as identified by participant 4, the principle of individualisation, allows social workers to acknowledge that even though individuals experience the same problems the cause of the problem, reactions and perceptions toward the problem might differ (Tripathi, 2013).

Subtheme 3: Mental health service delivery

Participants were asked whether they believed Kleinman's Explanatory Model was useful to mental health service delivery. All of the participants agreed that it is useful to mental health service delivery, thus one category emerged from the participants' narratives. This is discussed below.

Table 4.4.2: Participants' Narratives

Participant 8:	*"Yes I think it is helpful… even if it were blatantly obvious to you that there was something else going on it is still important to begin with what the person brings".*
Participant 9:	*"Yes I would most definitely say so… to not have any preconceived ideas of problems that your client might have but to really listen and meet the client where the client is really at."*

Category 1: Improving service delivery.

As presented above, in table 4.4.2., participants eight and nine agree that mental service delivery should begin with what the client describes as their need or problem. Furthermore, as highlighted by participant nine, social workers should listen attentively to their clients and therewith acknowledge what the client shares in service delivery.

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According to Bassett (2011), Jacob (2017), Kleinman (1980), & Petkari (2015), this allows the social worker to place their clients at the centre of mental health service delivery. It also allows the social worker to attain information surrounding why the client believes they may be experiencing the need or problem and how their culture or social group views it, what their standard approaches are and their expectations for service delivery. This not only promotes sensitivity but also allows the social worker to explore a client's beliefs, their culture and their local reality. According to the World Health Organisation (2019), this is essential because mental health is largely influenced by individual attributes, the social circumstances in which people find themselves in and the environment in which they live.

Subtheme 4: Social work practice

Participants were asked how often they believed social workers deliver intervention that aligned with Kleinman's Explanatory Model. Varying responses were received from the participants thus two categories emerged from the narratives. Each of these categories is discussed further below.

Table 4.4.3: Participants' Narratives

Participant 5:	*I think a lot of us are just in statutory mode <u>not doing prevention work or</u> focusing on actually how the client sees their problem, we <u>just move in and render services</u>".*
Participant 8:	*"I think <u>social workers are overwhelmed</u> so I don't know how well trained they are, I don't know how well they are using this".*
Participant 11:	*"The department <u>doesn't even respond when you report something that is urgent</u>. You know, and when they do, I very much doubt that, that [Kleinman's Explanatory Model] is taken into account by the majority of people".*

Category 1: Workload

High caseloads are prevalent among social workers practicing in South Africa and it is acknowledged as a significant stressor for social workers (Earle, 2008; McFadden, Taylor & Campbell, 2014; Pretorius, 2020). The National Department of Social Development advises that social workers should have no more than 60 cases.

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However, several studies conducted in South Africa have confirmed that social workers have between double and triple the amount prescribed by the National Department of Social Development (Baldauf, 2007; Joseph, 2017; Narsee, 2013 & Pretorius, 2020). Social workers, employed in the non-governmental sector, have between 110 and 400 cases whereas child protection social workers working in foster care, have as many as 500 cases (Baldauf, 2007; Joseph, 2017; Narsee, 2013 & Pretorius, 2020). The Department of Social Development confirms that there is a decline in productivity and quality of services when social workers experience high caseloads (DSD, 2009; Pretorius, 2020). The aforementioned is evident in the narratives presented above. Regardless of the work context that social workers are employed in, they experience challenges. According to Pretorius (2020), these include a high workload, lack of resources, poor remuneration and unsatisfactory working environments. This relates to the narratives presented above that social workers are overwhelmed and at times, may fail to respond to the need for intervention.

Furthermore, aligning with this, the narratives also imply that social workers may not have the time to actively engage with a client in the way that Kleinman's Explanatory Model implies. Richter & Dawes (2008) align with the aforementioned and confirm that progressive, right-based legislation and practise principles exist to guide social workers but it is not supported or resourced by services to fulfil its provisions. As a result, a social worker's performance may also decline due to the low morale, causing more stress and incidences of burnout. (Skhosana, 2020).

The narratives identify social workers as being overwhelmed and simply just "moving" into render services. Furthermore, the narratives also emphasize a lack of preventative services being practised thus imply that intervention is greatly focused at the tertiary level of prevention. It can thus be stated that high caseloads can have a negative effect on the social worker's ability to consider cultural beliefs in social work intervention as their focus is merely on crisis intervention rather than delivering intervention that acknowledges the influence of a client's cultural beliefs. Earle (2008) and Lombard (2008) align with the aforementioned and confirm that high caseloads contribute to social work practice being reduced to the level of crisis management.

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4.5. CONCLUSION

This chapter aimed to achieve the third objective of this study which is to empirically investigate the views of frontline social workers regarding the influence of cultural beliefs on social work intervention in mental health. The chapter began with providing a critical analysis of the research methodology that was utilised by the researcher to conduct this study. This was followed by the researcher providing a detailed description of the organisations the participants are employed in, their years of experience as social workers and in the field of mental health. The researcher then introduced three themes, subsequent sub-themes and categories that were established from the narratives and thoroughly examined each of these throughout this chapter. The next chapter will present various conclusions drawn from the empirical study and its appropriate recommendations.

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CHAPTER FIVE:

CONCLUSIONS AND RECOMMENDATIONS

5.1. INTRODUCTION

The purpose of this study has been to gain an understanding of the influence of cultural beliefs on social work intervention in mental health. A literature review indicated that despite the extensive influence culture has on the lives of all individuals and social work intervention, no other variable is so poorly informed and untested as culture (Singer et al., 2016). Furthermore, there is a need in research, to shift focus to social work intervention, thus including evaluations of evidence-based culturally appropriate methods of assisting individuals (Lund et al., 2012). Mental health in the context of South Africa, has consistently been described as rife and as a significant public health issue (Pillay, 2019). In accepting the call to assist with the aforementioned, this study aimed to give recognition to cultural beliefs, respect and acknowledge the multicultural South African population and therewith strengthen social work intervention in mental health.

This study attempted to formulate a conceptual framework for culture, cultural beliefs and social work intervention. Following this, it discussed mental health and provided a contextual framework for Kleinman's Explanatory Model, the theoretical point of departure for this study. An empirical study was conducted on the views of frontline social workers on the influence of cultural beliefs on social work intervention in mental health. This study was conducted in Cape Town, South Africa. Data was collected from fifteen participants by means of a semi-structured interview schedule. All interviews were conducted telephonically. Face-to-face interviews were no longer available as the study was not acknowledged by the South African government, under the Presidential Regulations, as an essential service related to the COVID-19 pandemic. The findings of the empirical study were presented and meticulously analysed in the previous chapter, chapter four. Building on the aforementioned chapter, this chapter speaks to the fourth objective of this study. It presents conclusions and makes recommendations on the influence of cultural beliefs on social work intervention in mental health to frontline social workers who are working in the

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field of mental health, tertiary and educational institutions, the South African Council of Social Service Professionals, and the National Department of Social Development.

5.2. CONCLUSIONS ON THE ATTAINMENT OF THE OBJECTIVES OF THE STUDY

The conclusions drawn below relate to the various objectives that were identified in chapter one of this study. Each of the objectives are individually discussed. Thereafter, the achievement of the objective is elaborated on. The objectives of the study were the following:

- To provide an overview of culture and conceptualize cultural beliefs and its influence on social work intervention.
- To provide a critical analysis of the influence of cultural beliefs on social work intervention in mental health using Kleinman's explanatory model.
- To empirically investigate the views of frontline social workers regarding the influence of cultural beliefs on social work intervention in mental health.
- To present conclusions and make recommendations on the influence of cultural beliefs on social work intervention in mental health to frontline social workers who are working in the field of mental health.

5.2.1. To provide an overview of culture and conceptualize cultural beliefs and its influence on social work intervention.

This study achieved this objective in chapter two of this study. In doing so, the chapter defined culture and cultural beliefs, provided a conceptual framework for social work intervention, described multicultural practice concepts useful to social work intervention, discussed social work intervention in South Africa, elaborated on social work and culture, and mental health and culture. Following this, chapter two explored the influence of cultural beliefs on social work intervention.

5.2.2. To provide a critical analysis of the influence of cultural beliefs on social work intervention in mental health using Kleinman's explanatory model.

This study achieved this objective in chapter three of this study. Chapter three defined mental health and thereafter discussed the approaches to mental health as well as the most commonly diagnosed mental health disorders in South Africa. This followed the

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discussion of social work intervention in mental health and thereafter, the influence of cultural beliefs on social work intervention in mental health. Following this, it provided a contextual framework for Kleinman's Explanatory Model, the theoretical point of departure for this study. Furthermore, mental health and Kleinman's Explanatory Model, were topics of discussion in the semi-structured interview schedule (attached as Annexure B). In doing so, the researcher attained the participants' understanding of mental health and as well as their views on the application of Kleinman's Explanatory Model in social work intervention. The participants' understanding of mental health and their view on Kleinman's Explanatory Model was further elaborated on in chapter four of study.

5.2.3. To empirically investigate the views of frontline social workers regarding the influence of cultural beliefs on social work intervention in mental health.

An empirical study on the views of frontline social workers on the influence of cultural beliefs on social work intervention in mental health was conducted. This study was conducted in Cape Town, South Africa from the 1st of February to the 31st of March 2021. Data was collected from fifteen participants by means of a semi-structured interview schedule (attached as Annexure B). The findings of this study were presented in chapter four of this study. Thus, this objective was achieved in chapter four of this study. In doing so, the participants' narratives were analysed and thereafter discussed through the identification of themes, sub-themes and categories. In total, three themes with ten subsequent sub-themes and its categories were identified from the narratives of the participants. Each of these were extensively discussed in chapter four of this study.

5.2.4. To present conclusions and make recommendations on the influence of cultural beliefs on social work intervention in mental health to frontline social workers who are working in the field of mental health.

In presenting conclusions and recommendations for the empirical study in this chapter (chapter five), the aforementioned objective is achieved. The findings and conclusions for this study has already been elaborated on in heading 5.2. of this chapter and the recommendations will soon follow in heading 5.3.

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5.2. SYNTHESIZED FINDINGS AND CONCLUSIONS

The conclusions drawn are based on the findings from the empirical study. Thereafter, recommendations are presented based on the conclusions drawn. Both the conclusions drawn and recommendations made are based on the information that emerged from each of the themes and subthemes identified in chapter four of this study. This allows for a well-rounded understanding of all the aspects related to the given themes. Furthermore, the participant particulars are discussed below and are useful as the lens through which the conclusions and recommendations can be understood.

5.2.1. Participant particulars

Providing individual profiles for participants creates a context for the interpretation of the conclusions and recommendations made for this study. Thus, the identifying details of the participants is elaborated on below. All participants of this study were frontline social workers, who are employed in the field of mental health in the Western Cape and who have at least two years' experience in delivering intervention in mental health. The majority of the participants had twenty or more years' experience both as a social worker and in the field of mental health. The second most prevalent group of participants were those who had zero to five years' experience as a social worker and in the field of mental health. The least most prevalent group of participants fell into two categories and included those who had between six and ten years' experience and sixteen and twenty years' experience as a social worker and in the field of mental health.

In acknowledging the aforementioned it can be stated that the participants were spread across those who are extensively experienced, medium-experienced and relatively inexperienced in the field of social work and mental health. Of the fifteen participants that were interviewed, nine are employed in the private sector, five are employed in the public or government sector, and only one participant is employed in the non-profit sector. Despite the differing work contexts, it is important to note that each of these participants, regardless of their work contexts, are required to comply with the regulatory frameworks, norms, standards and with the conditions of the registrations as per the South African Council of Social Service Professions. Thus, the

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context in which the participant is employed played no role in the findings or the interpretation of the data attained. This is largely because the aim of the study was focused on social work intervention and thus the individual social work practise of the participants.

5.2.2. Understanding Culture

A large variety of explanations were expected from the participants as literature suggests that culture is well recognised as a complex phenomenon, with an array of meanings. However, many of the participants simply described culture in relation to religion. In describing culture in relation to religion, the participants failed to express the many components that make up culture. Although it is well acknowledged that culture and religion are closely related to one another, religion is not sufficient in describing culture. It is often suggested that in order to understand culture, one needs to understand religion too. However, the complexity and various components of culture cannot be denied by simply relating it to religion.

Cultural beliefs were understood by a portion of the participants as being a part of child-rearing. In stating this, the participants stressed that cultural beliefs are ingrained in an individual and thus shaped their behaviours and at times, their thoughts. This aligns with literature. Literature confirms that cultural beliefs are transmitted from elders to children and that it plays a role in how individuals perceive, think and feel. Participants further expressed that cultural beliefs are a source of guidance to many and that it shapes interactions. Literature aligns with the aforementioned and agrees that cultural beliefs assist individuals to make sense of their world, provides a sense of safety, well-being, integrity and a sense of belonging.

However, a portion of the participants also expressed their understanding of cultural beliefs in relation to race. This does not align with literature. In fact, literature suggests that race is less complex when compared to culture and cultural beliefs. Moreover, race refers to differing biological characteristics that are often not associated with cultural beliefs or one's cultures. These biological characteristics include biological components such as skin colour, eye colour, and shape and hair type. Although it is acknowledged that cultural racism is prevalent in many communities, race does not

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amount to one's cultural beliefs or contribute to one's cultural beliefs. The participants also expressed that social workers may not be acknowledging cultural beliefs in social work intervention. In stating their reasoning for this participants emphasised that too little attention is paid to cultural beliefs, and that it is often neglected in social work intervention. This defies literature, particularly the Global Definition of Social Work, as the participants' narratives imply that social workers may be failing to respect diversity through the intervention they deliver. This lack of acknowledgement of cultural beliefs in social work intervention may also promote discriminatory social work intervention, insensitivity, disrespect and the misidentification of a client's need or problem.

When the participants' reasoning for this was questioned, they highlighted that the lack of acknowledgment of cultural beliefs in social work intervention may be related to the professional practice of social workers, their age and their effectiveness as a social worker. Despite the aforementioned, all participants agreed that the inclusion of a client system's cultural beliefs in social work intervention in mental health had positive effects. In turn, the participants expressed that this could improve the effectiveness of the intervention delivered and therewith intervention outcomes. Literature agrees with the aforementioned and confirms that the inclusion of cultural beliefs in social work intervention, in mental health, promotes an enhanced understanding between the social worker and the client. It also assists in building the professional relationship, trust and encourages the client's compliance to the intervention.

Conclusions

In conclusion, it is apparent that the participants do not have a clear understanding of culture. Thus, there is a need to educate social workers on culture. Although many participants describe cultural beliefs in alignment with literature, others described it in relation to race. Thus, it cannot be confidently concluded that all the participants have an understanding of cultural beliefs. Furthermore, the participants highlighted that the age of social workers, their professional practise, and their effectiveness as contributing to the inability to acknowledge cultural beliefs in intervention in mental health. Thus, it can be concluded that more seasoned (older) social workers may struggle with the acknowledgment of culture and cultural beliefs in social work

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intervention. Furthermore, the professional practice and effectiveness of the social worker may also hamper the social worker's ability to acknowledge cultural beliefs in social work intervention, in mental health.

5.2.3. Mental health and social work intervention

The participants described mental health as being holistic, thus acknowledging an individual's emotional, physical, mental and social well-being. The well-being perspective was also described by the participants as useful to understanding mental health. This perspective was further discussed in chapter four of this study. Thus, the participants' narratives closely align with what is suggested by literature. It also further aligns with the biopsychosocial and social approaches to mental health, as discussed in chapter three of this study. In alignment with literature, the participants identified educating their clients, sharing information, promoting awareness, speaking on behalf of their clients, and advocating for mental health services as key roles in mental health service delivery.

Conclusions

In conclusion, it can be stated that the participants have sufficient knowledge of both mental health and their roles in mental health service delivery. This is imperative as it implies that social workers understand what is expected of them when assisting those in need of mental health service delivery. As literature suggests, the services rendered by social workers in mental health service delivery, is a service delivered by no other medical professional. Thus, it is imperative that social workers are well aware of their roles and responsibilities in mental health service delivery.

5.2.4 Integration of models

It was acknowledged that none of the participants had any understanding of Kleinman's Explanatory model. Thus, the researcher imparted some education about the model. Thereafter, all participants agreed that Kleinman's Explanatory Model would be useful when applied to social work intervention. Their reasoning for this acknowledged the social work principles of acceptance and individualisation. The application of Kleinman's Explanatory Model in alignment with the principles of acceptance and individualisation allows the social worker to respond to the client in a

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unique, unbiased manner and that affords them both dignity and worth. It also encourages the social worker to listen attentively to their clients and encourages the input of cultural views. Furthermore, the participants agreed that Kleinman's Explanatory Model is beneficial to mental health service delivery. Literature agrees with the participants' views and emphasises that the Kleinman's Explanatory Model places the client at the centre of the service delivery, thus allowing them to express their views. In turn, this promotes sensitivity as well as an acknowledgment of culture. Despite this, the participants stressed that social workers may not always align their practise with the ideology of Kleinman's Explanatory Model. The participants identified high caseloads and poor working conditions as impeding the social worker's ability to acknowledge Kleinman's Explanatory Model in social work intervention. This aligns with literature as research has shown that social workers have between 110 and 400 cases as opposed to 60 that the National Department of Social Development prescribes. Furthermore, literature also suggests that social workers are faced with lack of resources, poor remuneration and unsatisfactory working environments. This further negatively influences their social work intervention. In turn, it negatively influences their ability to acknowledge Kleinman's Explanatory Model in social work intervention.

Conclusions

In conclusion, Kleinman's Explanatory Model is a model not known to the participants. However, it is important to note that this model is not a general social work model but rather one that is rooted in psychology. Thus, there was a general expectation that the participants may not have a clear understanding of Kleinman's Explanatory Model. Despite this, the participants agreed that Kleinman's Explanatory Model is useful in social work intervention in mental health. They agreed that it could significantly improve intervention and that it also elicited the role of the client in the intervention. However, it is further concluded that delivering intervention that aligned with Kleinman's Explanatory Model was not everyday practice of social workers. High caseloads and working conditions are identified as impeding this.

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5.3. RECOMMENDATIONS

The recommendations made below are based on the information that emerged from each of the themes and sub-themes identified in chapter four of this study. It also acknowledges the synthesized key findings and main conclusions that were discussed above.

5.3.1. Social work practice in mental health

Below, recommendations are made in relation to social work practice in mental health. Thus, it is relevant to social workers, the varying organisations that social workers are employed as well as policy regulators.

5.3.1.1. Social workers:

- It is recommended that social workers include both culture and cultural beliefs in social work intervention in mental health.

5.3.1.2. Social work organisations:

- It is recommended that organisations, employing social workers who are relatively in-experienced, make it compulsory that they attend workshops that would assist them in understanding the value of acknowledging culture in social work intervention in mental health.
- It is recommended that organisations employing more seasoned (older) social workers, make it compulsory for them to attend workshops that would help them in acknowledging culture and cultural beliefs in social work intervention.

5.3.1.3. Policy regulators:

- It is recommended that the South African Council of Social Service Professionals (SACSSP) include in their policy for continuous professional development (CPD) that social workers must attend training or workshops that focus on culture. This should be done at least once a year.
- It is recommended that The South African Council for Social Service Professions (SACSSP) and the National Department of Social development address the workload and working conditions of all social workers.

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- It is recommended that The National Department of Social Development monitor and evaluate the caseloads of all social workers, whether they are employed in the public or private sector.

5.3.2. Social work education

In making recommendations for social work education, the researcher will make reference to tertiary educational institutions offering undergraduate and postgraduate qualifications as well as the continuous professional development (CPD) that should be undertaken by all social work professionals. Recommendations will be made individually for each of these categories.

5.3.2.1. Tertiary educational institutions:

- It is recommended that tertiary education institutions explicitly educate social work students about culture and its components.
- It is recommended that culture be taught as a standalone module in the undergraduate social work qualification.
- It is recommended that social work students be exposed and assessed in their ability to acknowledge culture in social work intervention at the undergraduate level. This can be done through practice education.

5.3.2.3. Continuous professional development (CPD):

- It is recommended that social workers continually engage in continuous professional development (CPD) workshops and programmes surrounding mental health and mental health service delivery. This will assist in ensuring that their knowledge does not become outdated and remains relevant to the mental health needs of their clients.
- It is recommended that social workers continually engage in continuous professional development (CPD) workshops and programmes that explore culture, cultural beliefs, and social work intervention. This will assist in ensuring that their knowledge remains relevant to the current literature on each of the aforementioned.

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5.4. Further research

This research study aimed to gain an understanding of the influence of cultural beliefs on social work intervention in mental health. In order to gain the aforementioned understanding, this study conceptualised culture, cultural beliefs and therewith it's influence on social work intervention. Thereafter, a critical analysis was provided on the influence of cultural beliefs on social work intervention in mental health, using Kleinman's Explanatory Model. The researcher's findings from the empirical investigation showed the need to educate social workers about culture. It also showed that more seasoned (older) social workers may struggle with the inclusion of culture and cultural beliefs in social work intervention and that social workers may not explicitly acknowledge culture and cultural beliefs in social work intervention. Furthermore, the researcher also identified the need to address the workload and working conditions of social workers as this negatively impacts their ability to deliver intervention that acknowledges an individual's culture and their cultural beliefs. Thus, it is essential that the following research areas be further explored:

- A comparative study on the understanding of culture by newly qualified and seasoned social workers
- A qualitative study on the influence of eurocentrism on social worker's understanding of culture
- A qualitative study on the influence of globalisation on social worker's understanding of culture.
- A qualitative study on the influence of indigenization on social work practise in South Africa.

This research study should also be replicated in other provinces in South Africa. This will assist in generalising the researcher's findings. Also, the replication of this study in other provinces in South Africa could further promote insight and knowledge on the diversity and differences in and between cultures. Furthermore, it is important to note that one of the limitations of the study was that it only investigated the views of a small sample of social workers in Cape Town, in the Western Cape. Thus, there is room for the replication of this study in other areas of the Western Cape and in other provinces in South Africa.

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5.5 KEY FINDINGS AND CONCLUDING REMARKS

This research study aimed to gain an understanding of the influence of cultural beliefs on social work intervention in mental health. It acknowledged the views of frontline social workers, practising in the field of mental health. A number of factors warranted the need for this study. These factors included the absence of studies exploring or investigating culture, the need to shift towards investigating more culturally-appropriate methods of intervention and the rife statistics of mental health in South African. The researcher interviewed, transcribed and diligently analysed 15 participants' discourses. During this process, the researcher also conducted member-checking to ensure that the discourses were a true reflection of the participants' narratives. The following was identified as the key findings and main conclusions for this study: social workers do not have a clear understanding of culture. Thus, it is challenging for them to further acknowledge culture and cultural beliefs in social work intervention. Also, more seasoned (older) social workers struggle with the inclusion of culture and cultural beliefs in social work intervention. Thus, further extending the need to educate social workers, both inexperienced and extensively-experienced on culture.

Furthermore, social workers may not explicitly acknowledge culture and cultural beliefs in social work intervention. The participants attributed this to high caseloads and poor working conditions. Thus, the responsibility of acknowledging culture and cultural beliefs in social work intervention not only lies with the social worker but should also be holistically promoted by tertiary educational institutions, training institutions, the South African Council of Social Service Professionals, and the National Department of Social Development. The dissemination of these research findings are of great value in South Africa where approximately 30 cultural groups exist and where mental health statistics are rife. Thus, the recommendations made in this study contributes to the body of knowledge and practise of social work in South Africa and can play a role in improving the well-being of those in the country.

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ANNEXURE A
INFORMED CONSENT FORM

INFORMED CONSENT TO PARTICIPATE IN THE RESEARCH ON THE INFLUENCE OF CULTURAL BELIEFS ON SOCIAL WORK INTERVENTION IN MENTAL HEALTH: VIEWS OF FRONTLINE SOCIAL WORKERS.

You are asked to partake in a research study conducted by Keagan Blight, a master's student from the Department of Social Work at the University of Stellenbosch. The results attained will contribute to the abovementioned thesis, become a part of its research report, and thereafter a peer-reviewed journal. You were selected as a possible participant in this study because you are a frontline social worker and deemed eligible to participate in the study. Your participation in this research will be done so in your personal professional capacity therefore not in representation of the organization under which you are employed.

1. Purpose of the study

The purpose of this study is to gain an understanding of the influence of cultural beliefs on social work intervention in mental health, as viewed by frontline social workers. If you volunteer to participate in the study you will be asked to do the following:

- Be available for a one-on-one semi-structured telephonic interview at your convenience, as determined and agreed upon by you and the researcher.
- If any further information is required about this research study, you are welcome to contact the researcher via email at 18243703@sun.ac.za.

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2. Potential risk and discomfort

No harm is foreseen during or after the research is completed. Any uncertainties you may experience during the one-on-one interview with the researcher can be addressed and discussed at any given time. The research is considered a low-risk study in terms of ethical considerations. Confidentiality will be upheld throughout all interviews and no personal, identifying information, will be shared or included within the research report.

3. Confidentiality

The researcher will conduct one-on-one telephonic interviews with each of the participants. No personal identifying information, of those participating in the study, will be recorded. The researcher will use a mobile application to record the one-on-one telephonic interviews with participants and thereby attain data. The data collected will be stored in a password-protected mobile device, stored in a password-protected cloud registered in the researcher's name, and all transcribed hard copies of the data will be stored in a locked cabinet at the researcher's residence. All identifying personal information and recorded data will remain confidential and will not be disclosed unless permission to do has been granted by you.

4. The potential benefit to subject or society

The results of this study can promote an understanding of how frontline social workers view the influence of cultural beliefs on social work intervention in mental health. The attained data can be used to improve service delivery within the South African context, and particularly for those who struggle with ill mental health.

5. Participation and withdrawal

Your participation in this study is entirely voluntary. If you volunteer to partake in this study, you are free to withdraw at any given time, free of consequences. Participants are free to refuse to answer questions they wish not to answer. The refusal to answer questions will not exclude the participant from the study. However, the researcher may withdraw you, as a participant, within the study, if the circumstances warrant doing so.

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6. Identification of investigators

Should any additional information be required regarding this research study, you are welcome to contact the researcher, Keagan Blight, through telephone at 064 210 0320 or via email at 18243703@sun.ac.za. If you have any questions or concerns about this research study, you are free to contact the supervisor, Dr. ZF. Zimba, at the Department of Social Work, Stellenbosch University, via email at zfzimba@sun.ac.za or by telephone 021 808 2488.

7. Rights of research participants.

Participants are free to withdraw consent to participate at any given time. This can be done without penalty or consequence and are not obliged to waive any legal claims, rights, or remedies due to your participation in this study.

8. Payment for participation

The cost of this research study will be carried by the researcher and no costs will be expected from the participants. Participants will not receive any remuneration from the researcher for their participation in this research study.

Signature of the research participant

The information above was explained and described to me by Keagan Blight.

I…………………………………………………………………… (name of participant) was given the opportunity to ask questions and these questions were answered to my satisfaction.

I hereby consent to voluntarily participate in this study. I have been given a copy of this form.

_____________________________ _____________________________

Full name of participant | Signature of participant

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I declared that I explained the above information given in this document to ………………………………………………………………………………… (participant name). He/she was given sufficient opportunity to ask any questions.

____

Signature of the investigator

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ANNEXURE B:

SEMI-STRUCTURED INTERVIEW SCHEDULE

The questions below will be used to guide the interaction between the research and the participants.

SECTION A:

Identifying Information

- Area of practice or specialization
- Experience, in years, practicing as social work professional
- Experience, in years, within the mental health sector.

SECTION B:

THEMES FOR INTERVIEW AND THE RELATED QUESTIONS

Theme One: Culture, the conceptualisation of cultural beliefs, and its influence on social work intervention.

- How would you describe culture?
- What is your understanding of cultural beliefs?
- In your personal opinion, how frequently are cultural beliefs acknowledged in social work intervention?
- What is the influence of cultural beliefs on social work intervention, particularly in mental health?

Theme Two: Mental health and social work intervention, in the South African context

- What is your understanding of mental health?
- What do you believe is the role of a social worker in mental health service delivery?

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Theme Three: Social work intervention using Kleinman's explanatory model.

- What is your understanding of Kleinman's explanatory model?
- In your opinion, how useful is the explanatory model in social work intervention?
- Is Kleinman's explanatory model a useful point of departure in mental health? How often do social workers deliver intervention that aligns with Kleinman's explanatory model.

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ANNEXURE C
REC APPROVAL LETTER

REC: Social, Behavioural and Education Research (SBER) – Initial Application Form

24 February 2021

Project number: 19399

Project title: The Influence of Cultural Beliefs on Social Work Intervention in Mental Health: Views of Frontline Social Workers.

Dear Miss Keagan Blight

Co-investigators:

Your response to stipulations submitted on 23/02/2021 12:13 was reviewed and approved by REC: Social, Behavioural and Education Research (REC:SBE).

Please note below expiration date of this approved submission

Ethics approval period:

Protocol approval date (Humanities)	Protocol expiration date (Humanities)
12 February 2021	11 February 2024

GENERAL REC COMMENTS PERTAINING TO THIS PROJECT:

INVESTIGATOR RESPONSIBILITIES

Please take note of the General Investigator Responsibilities attached to this letter. You may commence with your research after complying with these guidelines.

If the researcher deviates in any way from the proposal approved by the REC: SBE, the researcher must notify the REC of these changes.

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Please use your SU project number (19399) on any document or correspondence with the REC concerning your project.

Please note that the REC has the prerogative and authority to ask further questions, seeks additional information, require further modification, or monitor the conduct of your research and the consent process.

INVESTIGATOR RESPONSIBILITIES

Please take note of the General Investigator Responsibilities attached to this letter. You may commence with your research after complying fully with these guidelines.

If the researcher deviates in any way from the proposal approved by the REC: SBE, the researcher must notify the REC of these changes.

Please use your SU project number (19399) on any documents or correspondence with the REC concerning your project.

Please note that the REC has the prerogative and authority to ask further questions, seek additional information, require further modifications, or monitor the conduct of your research and the consent process

CONTINUATION OF PROJECTS AFTER REC APPROVAL PERIOD

Please note that a progress report should be submitted to the REC: SBE before the approval period has expired if a continuation of ethics approval is required. The Committee will then consider the continuation of the project for a further year (if necessary).

Once you have completed your research, you are required to submit a final report to the REC: SBE for review

Included Documents:

Document Type	File Name	Date	Version
Research Protocol/Proposal	FINAL Miss Blight Proposal Nov 2020 DESC Review	21/12/2020	1
Recruitment material	LETTER OF REQUEST	21/12/2020	1
Data collection tool	Interview Schedule	21/12/2020	1
Informed Consent Form	INFORMED CONSENT FORM	21/12/2020	1

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Default	TEMPLATE FOR RESPONSE LETTER	21/02/2021
Default	Miss Blight Proposal Nov 2020 DESC Review	21/02/2021

If you have any questions regarding this application or the conditions set, please contact the REC Secretariay at cgraham@sun.ac.za.

Sincerely,

Clarissa Graham
Secretariat: Research Ethics Committee: Social, Behavioural and Education Research (REC: SBE)

National Health Research Ethics Committee (NHREC) registration number: REC-050411-032.
The Research Ethics Committee: Social, Behavioural and Education Research complies with the SA National Health Act No.61 2003 as it pertains to health research. In addition, this committee abides by the ethical norms and principles for research established by the Declaration of Helsinki (2013) and the Department of Health Guidelines for Ethical Research: Principles Structures and Processes (2nd Ed.) 2015. *Annually a number of projects may be selected randomly for an external audit.*

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ANNEXURE D:
PRINCIPAL INVESTIGATOR RESPONSIBILITIES
PROTECTION OF HUMAN RESEARCH PARTICIPANTS

As soon as Research Ethics Committee approval is confirmed by the REC, the principal investigator (PI) is responsible for the following:

Conducting the Research: The PI is responsible for making sure that the research is conducted according to the REC-approved research protocol. The PI is jointly responsible for the conduct of co-investigators and any research staff involved with this research. The PI must ensure that the research is conducted according to the recognised standards of their research field/discipline and according to the principles and standards of ethical research and responsible research conduct.

Participant Enrolment: The PI may not recruit or enrol participants unless the protocol for recruitment is approved by the REC. Recruitment and data collection activities must cease after the expiration date of REC approval. All recruitment materials must be approved by the REC prior to their use.

Informed Consent: The PI is responsible for obtaining and documenting affirmative informed consent using only the REC-approved consent documents/process, and for ensuring that no participants are involved in research prior to obtaining their affirmative informed consent. The PI must give all participants copies of the signed informed consent documents, where required. The PI must keep the originals in a secured, REC-approved location for at least five (5) years after the research is complete.

Continuing Review: The REC must review and approve all REC-approved research proposals at intervals appropriate to the degree of risk but not less than once per year. There is no grace period. Prior to the date on which the REC approval of the research expires, it is the PI's

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responsibility to submit the progress report in a timely fashion to ensure a lapse in REC approval does not occur. Once REC approval of your research lapses, all research activities must cease, and contact must be made with the REC immediately.

Amendments and Changes: Any planned changes to any aspect of the research (such as research design, procedures, participant population, informed consent document, instruments, surveys or recruiting material, etc.), must be submitted to the REC for review and approval before implementation. Amendments may not be initiated without first obtaining written REC approval. The only exception is when it is necessary to eliminate apparent immediate hazards to participants and the REC should be immediately informed of this necessity.

Adverse or Unanticipated Events: Any serious adverse events, participant complaints, and all unanticipated problems that involve risks to participants or others, as well as any research-related injuries, occurring at this institution or at other performance sites must be reported to the REC within five (5) days of discovery of the incident. The PI must also report any instances of serious or continuing problems, or non-compliance with the RECs requirements for protecting human research participants.

Research Record Keeping: The PI must keep the following research-related records, at a minimum, in a secure location for a minimum of five years: the REC approved research proposal and all amendments; all informed consent documents; recruiting materials; continuing review reports; adverse or unanticipated events; and all correspondence and approvals from the REC.

Provision of Counselling or emergency support: When a dedicated counsellor or a psychologist provides support to a participant without prior REC review and approval, to the extent permitted by law, such activities will not be recognised as research nor the data used in support of research. Such cases should be indicated in the progress report or final report.

Final reports: When the research is completed (no further participant enrolment, interactions or interventions), the PI must submit a Final Report to the REC to close the study.

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On-Site Evaluations, Inspections, or Audits: If the researcher is notified that the research will be reviewed or audited by the sponsor or any other external agency or any internal group, the PI must inform the REC immediately of the impending audit/evaluation.

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ANNEXURE E
REFLEXIVITY REPORT

Reflexivity is the process of continual internal dialogue, critical self-evaluation, active acknowledgment, and explicit recognition that the researcher's position may affect the research process, data analysis, and the outcome of the study (Reid, Brown, Smith, Cope and Jamieson, 2018). According to Ruokonen-Engler & Siouti (2016), reflexivity is a useful approach in qualitative research as it assists the researcher in reflecting on the meaning of their own entanglements in the research process. Leading from the aforementioned, Ruokonen-Engler & Siouti (2016), offer six questions that allow the researcher to explore their reflexivity. These will be answered below.

1. What personal experience do I have with my research topic?

Upon initiating my master's thesis, I was employed in an emergency response centre, as a support officer. Although I was not directly employed as a social worker, I witnessed the value of culture as well as the great influence it has on the lives of many individuals. It was often very difficult to deliver counselling or debriefing without the direct knowledge of the individual's culture. This always concerned me and I feared insulting the individual or requesting that they practise coping mechanisms that were discriminatory or beyond the norms or values of their culture.

2. How did I come to study the specific topic in the field?

This topic is both a professional and personal interest that I developed throughout the completion of my undergraduate social work degree. I believe my interest in culture was sparked during my placement at child protection organisations in both my third and fourth year. It always concerned me that social workers were often delivering intervention at the tertiary level of intervention. As a result, I felt that we were assisting individuals in a response to a crisis and in a "one brush fits all" way and this was concerning. I chose mental health as a focus because I believe that it is often a

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diagnosis that both fails to acknowledge culture and also one that receives stigma because of culture. Thus, culture, mental health and social work intervention were combined to comprise the focus of this study.

3. What is my relationship to the topic being investigated?

I saw first-hand how difficult it was to deliver intervention to individuals without the knowledge of their culture. Also, this alerted me how easily culture could be neglected when delivering crisis intervention. I feared being labelled as inadequate as a professional because I had requested an individual to practise skills that were discriminatory to their culture. Thus, managing the influence of culture as well as the fear of what could happen when culture is not acknowledged in intervention are aspects that I had first-hand experience with.

4. How did I gain access to the field?

Completing practise education during my undergraduate degree granted me the opportunity to build professional relationships with many social workers, in diverse fields of practise. These social workers, coupled with those, who I had completed my undergraduate degree with, became participants of this study. Thus, I gained access to the participants through using my own professional network.

5. How does my own position (age, class, ethnicity, economic status etc.) influence interaction in the field and the data collection process?

It can be stated that my culture differs from the participants as well as to the clients that we serve. Thus, there were diverse beliefs, values, norms and morals interacting with one another when I conducted the interviews. However, this study aimed to gain an understanding of culture, cultural beliefs and its influence on social work intervention in mental health. As a result, this study did not focus on any specific culture nor did it aim to explain or examine one culture, compared to another. Thus, my belonging to a given culture did not influence the interaction in the field or through the data collection process. Being a social worker myself, I upheld the principles of a non-judgmental attitude, acceptance, individualisation as well as active listening skills to guide my interviews with the participants. Thus, my own position or culture did not hamper the interaction or the data collection process.

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6. What is my interpretation perspective?

During the data analysis, it became evident that my first-hand experience with culture and acknowledging culture in intervention led to me upholding a subjective perspective. This occurred as I felt that I could relate to the practicipants, their views and their experiences. Furthermore, while completing the interviews and the data analysis, I became employed as a social worker and found it difficult to become fully detached. As a result, I became concerned of my own biases. To prevent this from influencing my analysis of the participants' narratives, I used member-checking to ensure the validity of my transcriptions as well as engaged in reflexive journaling. I also regularly communicated with my supervisor about the participants' narratives. This has assisted me in remaining unbiased.