Caregivers’ perceptions of their involvement in children’s mental health and mental health services: a qualitative study amongst caregivers of primary school aged children in the Western Cape, South Africa

By

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Abstract

Introduction. The poor mental health of children and young people is a global crisis. South African children are at an increased risk of developing mental health problems due to their exposure to multiple risk factors, including poverty, HIV/AIDS, and poly-victimisation. Children and young people who are at risk of developing a mental health problem depend on their parents or caregivers (any person responsible for the daily care of a child) to recognise problems and access appropriate mental health support. Studies, most of which were conducted in high-income countries, have shown that parents/caregivers experience a plethora of barriers and facilitators associated with recognising problems within their children and accessing services for a variety of reasons including systemic-structural, attitudinal, and family circumstances. However, it is unclear how South African parents/caregivers perceive their involvement in recognising and responding to their children's mental health problems. In this study, I sought to explore how South African parents/caregivers conceptualise mental health and how they deal with potential mental health problems in the family context. I also sought to explore how they perceive their role in their children's mental wellbeing, and the barriers and facilitators associated with this role.

Methods. Participants were 31 parents/caregivers of primary school aged children. I conducted in-depth, semi-structured interviews with 10 parents/caregivers of children (aged 11–14) attending a primary school in the Western Cape area. Secondary data from interviews with a further 21 participants in similar contexts were incorporated. I analysed the data as a single corpus using reflexive thematic analysis and ATLAS.ti version 8 software.

Findings. I identified four superordinate themes: (1) understandings of mental health terminology, (2) coping with mental health problems, (3) the parents'/caregiver's role in children's mental health and mental health services, and (4) barriers/facilitators to parent/caregiver involvement in children's wellbeing. Although participants struggled to articulate their understanding of mental health terminology, they made use of various models to explain the cause of mental health problems and showed great awareness of the consequences if these problems are left untreated. Participants made use of several strategies to ensure their emotional availability to their children so that they could recognise and respond to mental health problems. However, participants face multiple barriers and can rely on different facilitators in their involvement. Lack of knowledge and resources to deal with wider contextual factors, such as poverty, other responsibilities, family dynamics, and poly-victimisation, often cause participants to use avoidance as a coping mechanism. Participants also found it difficult to recognise emotional distress and mental health problems and distinguish between problematic and normal adolescent behaviour. Participants often believed their children's mental health problems were not serious enough to warrant engagement with child and adolescent mental health services, and even if they did wish to do so, they did not know where to seek support. Although participants found it acceptable to seek support from their social networks, they were often concerned over confidentiality and trust. Participants who have engaged with mental health services, often through referrals, reported positive experiences and valued a good therapeutic relationship, knowledge, and the support they received.

Conclusion. The findings highlight the need for parent/caregiver support in understanding, recognising, and appropriately responding to their children's mental health problems. Supporting parents/caregivers on these fronts will promote their availability and appropriate mental health help-seeking for children experiencing a mental health problem. The findings highlight the need for further research and the development of appropriate interventions.

Opsomming

Inleiding. Die geestesgesondheid van kinders en jongmense is ‘n wêreldwye krisis. Suid-Afrikaanse kinders het ‘n hoë risiko vir die ontwikkeling van geestesgesondheidsprobleme as gevolg van hul blootstelling aan verskeie risiko-faktore soos armoede, MIV/VIGS en poli-viktimisering. Kinders en jongmense, wie ‘n hoë risiko loop om geestesgesondheidsprobleme te ontwikkel, is afhanklik van hul ouers/versorgers (enige persoon verantwoordelik vir die daaglikse versorging van ‘n kind of jongmens) vir die herkenning van moontlike geestesgesondheids probleme en toegang tot gepaste ondersteuning. Volgens studies, wat meerendeels in hoë-inkomste lande uitgevoer is, ervaar ouers/versorgers talle hindernisse en fasiliterende faktore geassosieer met die herkenning van geestesgesondheidsprobleme en die toegang tot dienste, insluitende sistemies-strukturele faktore, gesindhede en familie omstandighede. Dit is egter onduidelik hoe Suid-Afrikaanse ouers/versorgers hul betrokkenheid in die herkenning van en reaksie tot hul kinders se geestesgesondheidsprobleme beskou. In hierdie studie het ek ten doel gehad om uit te vind hoe Suid-Afrikaanse ouers/versorgers geestesgesondheid beskou en moontlike geestesgesondheidsprobleme in die familie-konteks hanteer. Ek het ook ten doel gehad om hul sieninge rondom die rol wat hulle speel in hul kinders se geestesgesondheid en welsyn en die hindernisse en fasiliterende faktore wat hulle in hierdie kapasitiet teëkom, te ondersoek.

Metodes. Die deelnemers was 31 ouers/versorgers van laerskoolkinders. Ek het in-diepte, semi-gestruktureerde onderhoude met 10 ouers/versorgers van laerskoolkinders, tussen die ouderdom van 11 en 14 jaar, aan ‘n Wes-Kaapse laerskool gevoer. Sekondêre data van ‘n verdere 21 deelnemers in soortgelyke omstandighede is geïnkorporeer. Ek het die data as ‘n enkele korpus geanaliseer deur die gebruik van refleksiewe tematiese analise en ATLAS.ti weergawe 8 sagteware.

Bevindinge. Ek het vier hooftemas geïdentifiseer: (1) begrip van geestesgesondheidsterminologie, (2) hantering van geestegesondheidsprobleme, (3) die rol van die ouer/versorger in kinders se geestesgesondheid en toegang tot geestesgesondheidsdienste, en (4) faktore wat die ouer/versorger se betrokkendheid by die kind se welstand verhinder of fasiliteer. Alhoewel deelnemers gesukkel het om hul verstaan van geestesgesondheidsterminologie te verwoord, het hulle nietemin gebruik gemaak van verskeie modelle om die oorsake van geestesgesondheidsprobleme te verduidelik en het hulle bewustheid van die gevolge van onbehandelde geestesgesondheidsprobleme getoon. Deelnemers het van verskeie strategieë gebruik gemaak om hulself emosioneel beskikbaar te stel vir hul kinders en om geestesgesondheidsprobeleme te herken en aan te spreek. Nietemin, word deelnemers in hul betrokkendheid met verkeie hindernisse en fasiliterende faktore gekonfronteer. ‘n Tekort aan die nodige kennis en hulpbronne om die wyer kontekstuele probleme soos armoede, ander verantwoordelikhede, familie-dinamika en poli-viktimisering te hanteer, lei daartoe dat ouers/versorgers vermyding gebruik as ‘n manier om geestesgesondheidsprobleme te hanteer. Daarbenewens het deelnemers ook gesukkel om emosionele nood en geestesgesondheidsprobleme te herken en om tussen normale- en problematiese tienergedrag te onderskei. Deelnemers was meerendeels van die oortuiging dat hul kinders se geestesgesondheidsprobleme nie ernstig genoeg is om die betrokkendheid van kinder- en tiener geestesgesondheidsdienste te regverdig nie. Diegene wat wel geestesgesondheidsdienste wou betrek het nie geweet hoe om hulp te bekom nie. Alhoewel deelnemers gevoel het dat dit aanvaarbaar is om ondersteuning van hul sosiale netwerke te vra, was hulle besorgd oor aspekte soos vertroulikheid en vertroue. Deelnemers wie al betrokke was by geestesgesondheidsdienste, dikwels deur middel van verwysings, het getuig van positiewe ervarings en het waarde geheg aan ‘n goeie terapeutiese verhouding, asook die kennis en ondersteuning wat hulle ontvang het.

Slot. My bevindinge dui op die behoefte aan ondersteuning vir ouers/versorgers in hul verstaan- en herkenning van, en gepaste reaksie op hul kinders se geestesgesondheidsprobleme. Deur ouers/versorgers op die manier te ondersteun, kan hul beskikbaarheid rakende en gepaste soeke na hulp vir kinders met geestesgesondheidsprobleme bevorder word. Hierdie bevindinge onderstreep ook die behoefte aan verdere navorsing en die ontwikkeling van gepaste intervensies.

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List of Abbreviations

DALY - Disability-adjusted life year

BCT - Behavioural change theory

CAMH - Child and adolescent mental health

CAMHS - Child and adolescent mental health services

COVID-19 - Coronavirus disease of 2019

CYP - Children and young people

HIC - High-income country

HIV/AIDS - Human immunodeficiency virus / acquired immunodeficiency syndrome

LIM - Low- and middle-income country

MH - Mental health

MHS - Mental health services

NGO - Non-governmental organisation

PTSD - Post-traumatic stress disorder

RCT - Randomised controlled trials

SASH - South African Stress and Health Survey

TA - Thematic analysis

YLD - Years of life lived with disability

WCED - Western Cape Education Department

WHO - World Health Organization

WMH - World Mental Health Survey

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Chapter 1

Introduction

In this chapter I provide a broad overview of the literature on the global and local mental health crisis. I then discuss the role of parents/caregivers in recognising and responding to possible mental health problems in children and young people who are at risk of developing a mental health problem. Parents/caregivers refer to any person responsible for the daily care of a child and hereto referred to as caregivers. Thereafter, I discuss caregivers' perceived barriers and facilitators in their recognition and response to their children's possible mental health problems. Finally, I discuss the rationale for the research study and present its research questions and objectives. I then provide a brief outline of the thesis document.

Background

The prevalence of mental health problems among the global adult population is a major issue. It has been estimated that 29.2% of individuals experience a common mental health problem (depression, anxiety, and substance abuse) across their lifetime (Steel et al., 2014). These common mental health problems often take root during childhood, with an estimated 50% of life time mental health problems starting by the age of 14 (Belfer, 2008; Kessler et al., 2005). It has been estimated that one out of eight children and young people (CYP) are directly affected by any mental health problem (Costello et al., 2003; Kieling et al., 2011; Polanczyk et al., 2015). Although epidemiological data concerning child and adolescent mental health (CAMH) in low- and middle-income countries (LMIC) are sparse, it has been suggested that prevalence rates may be higher than the global average (Erskine et al., 2017). In South Africa, CYP may be at a high risk of developing mental health problems due to their exposure to multiple risk factors, including poverty, HIV/AIDS, and poly-victimisation (Kieling et al., 2011; Lund et al., 2011; Patel et al., 2010; Skeen et al., 2019).

Indeed, available data have estimated prevalence rates of common mental health problems (such as depression and anxiety) among CYP to be as high as 17% (Kleintjes et al., 2006) or between 22 and 25.6% (Perold, 2001).

Despite the need for mental health support for CYP, a major treatment gap remains in addressing these issues. Available data on the global adult population have estimated that the treatment gap often exceeds 50%, while in South Africa it has been suggested to be as high as 75% (Alem et al., 2009; Patel et al., 2010; Saxena et al., 2007; Williams et al., 2008). This means that only about a quarter of adults who are experiencing a common mental health problem receive some form of treatment (Herman et al., 2009; Seedat et al., 2009; Seedat et al., 2008). Although similar data on CYP's use of mental health services are scarce, it has been estimated that the one-year treatment prevalence for CYP is about 24% of that of the adult population (Morris et al., 2011). In an attempt to reduce the treatment gap among CYP living in LMICs, many interventions have focused on promoting help-seeking (Xu et al., 2018) or providing school-based mental health programmes and services (Barry et al., 2013; Fazel et al., 2014). The success of help-seeking and mental health programmes aimed at children is, however, highly dependent on the involvement of the CYP's caregivers (Haine-Schlagel & Walsh, 2015).

CYP depend on their caregivers for mental health support, as they are often the first to recognise mental health problems and initiate the help-seeking process (Boulter & Rickwood, 2013; Gulliver et al., 2010; Hassett et al., 2018; Wahlin & Deane, 2012). Caregivers have the potential to act as agents to support their child who is experiencing a mental health problem. However, multiple studies have identified that caregivers experience various barriers and can rely on some facilitators in their involvement in CAMH and child and adolescent mental health services (CAMHS) (Hassett et al., 2018; Honey et al., 2015; Reardon et al., 2017, 2018, 2020; Skylstad et al., 2019). These studies have often identified systematic-structural barriers (such as the availability and cost of services and logistical barriers in accessing such services), attitudes and beliefs regarding mental health services and treatment (including beliefs regarding the therapeutic relationship and the efficacy and consequences of treatment), mental health literacy (which is the knowledge and understanding of mental health problems and the help-seeking process), as well as family circumstances (other responsibilities and family support network). Understanding the type and extent of caregivers' perceived barriers could help inform future interventions to promote help-seeking and to ensure that families receive the appropriate support.

Rationale and Motivation for this Research Study

Although there is growing global literature on the involvement of caregivers in their children's mental health (MH) and mental health services (MHS) and their perceptions of the associated barriers and facilitators, the majority of these studies have been conducted in high-income countries (HIC) (Hurley et al., 2020; Reardon et al., 2017). To my knowledge, no such study has been conducted in South Africa. Although these research studies have deepened our understanding of caregiver involvement in children's mental health, simply transferring research findings gathered in HIC to LMIC contexts is fraught with assumptions, possibly leading to important contextual and cultural factors being overlooked (Osborn et al., 2020). This is especially relevant to South Africa with its great cultural and contextual diversity. This research study will be the first to explore caregivers' perception of their involvement in their children's MH and MHS in the South African context. This study will add to the literature by providing a preliminary understanding of how South African caregivers perceive their role in their children's mental health, conceptualise mental health, deal with their child's and their own mental health problems, and how they perceive the barriers to and facilitators of their involvement. Furthermore, the findings of this research study will produce foundational work to highlight future research avenues and could potentially inform future interventions aimed at providing support to caregivers.

Research Question and Objectives

In this research study, I attempt to explore how caregivers perceive their involvement in their children's MH and MHS. Specifically, my research question is: How do caregivers perceive their involvement in their children's mental health and mental health services? The following objectives directed my search for an answer to the research question:

1. To explore how caregivers understand and conceptualise mental health and mental health services;
2. To explore how caregivers think about and deal with their own mental health problems in the context of the household;
3. To explore how caregivers think about and understand the mental health problems their child faces;
4. To understand caregivers' perceptions of the barriers to and facilitators of mental health services; and
5. To explore caregivers' perceptions of their role in children's mental health and mental health services.

Overview of the Thesis

The thesis consists of five chapters. In Chapter 2, I explore the literature on the mental health crisis among adults and children, the involvement of caregivers in the mental health help-seeking process, and the barriers and facilitators they encounter. This section includes global, LMIC, and South African literature sources. In Chapter 3, I discuss the theoretical framework within which this study is located, with special attention to the research paradigm, the approach to literature and theory, as well as the theoretical orientation. In Chapter 4, I detail the methods followed in this research study, the implications of the COVID-19 pandemic for the research strategy, as well as the ethical considerations and strategies I employed to ensure the trustworthiness of qualitative research. In Chapter 5, I report on the findings of this research study, which consists of four themes and 14 subthemes. In Chapter 6, I discuss the findings of the study, highlighting the clinical and research implications. I then provide an outline of the strengths and limitations of the study and end with a conclusion.

Chapter 2

Literature Review

Introduction

In this chapter, I present a summary on the global and local prevalence rates of mental health problems among adults and discuss the current mental health treatment gap and use of services. I follow this with an overview of the status of CAMH, both globally and in South Africa. I highlight the importance of addressing mental health problems during childhood and adolescence, the prevalence of mental health problems among CYP, and common risk and protective factors to which South African CYP are exposed. Thereafter, I discuss the role of caregivers in addressing mental health problems among their children and provide insights into the possible barriers and facilitators caregivers may encounter as agents in their children's mental health journey. Common barriers and facilitators are reported, which includes poor CAMHS provision, lack of appropriate legislation/policy, the inaccessibility of CAMHS, caregivers' attitudes and beliefs towards CAMHS, other family responsibilities, and mental health literacy. I conclude this chapter with the mutual benefits and challenges of involving caregivers in interventions and programmes aimed at promoting CYP mental wellbeing.

The Mental Health of Adults Globally and in South Africa

Prevalence Rates of Mental Health Problems

Globally, more than 450 million people are affected by common mental health problems, with the global prevalence estimated to be 4.4% for depression and 3.6% for anxiety disorders (World Health Organization, 2017). Approximately 29.2% of people experience a common mental health problem in their lifetime, including depression, anxiety, and substance abuse (Steel et al., 2014). These common mental health disorders cause a considerable burden of disease, being the highest contributor (32%) to years of life lived with disability (YLD) and constituting 13% of disability-adjusted life years (DALY) (Vigo et al., 2016).

Individuals living in LMICs may be disproportionally affected by mental health problems compared to the global averages. For instance, more than 80% of individuals experiencing a common mental health problem are living in LMICs (WHO, 2004). Specifically in South Africa, individuals have a 16.5% 1-year prevalence rate and a lifetime 30.3% lifetime rate for any mental health problem. The Western Cape showed the highest lifetime prevalence rates at 39.4%, with the prevalence of anxiety disorders, mood disorders, and substance use disorders being 18.9%, 13.7%, and 20.6% respectively (Herman et al., 2009). Compared to other countries globally, South Africa has a high prevalence rate of anxiety and mood disorders, with only eight countries (out of 24) scoring higher for anxiety and nine for mood disorders (Andrade et al., 2014). Furthermore, 26% of diagnosed mental health disorders among South Africans are considered to be severe, with only three countries having higher rates (Andrade et al., 2014). Consequently, South Africans have both a relatively high prevalence and severity of mental health problems compared to other countries.

The Mental Health Treatment Gap

Despite the urgency to address the burden of mental health problems, a treatment gap remains for many individuals living with mental health problems. In all countries worldwide, the treatment gap often exceeds 50% and approaches a staggering rate of 90% in LMICs (Alem et al., 2009; Patel et al., 2010; Saxena et al., 2007). In South Africa, it has been estimated that the treatment gap is around 75% (Williams et al., 2008). This means that of all South Africans who require mental health care, only 25% receive treatment.

Although effective treatments exist for most common mental health problems, adequate access to mental healthcare remains a challenge in LMICs (Patel et al., 2013). For instance, the number of psychiatrists practicing on the continent of Africa (with a population of almost a billion) is lower than the number of available psychiatrists in a US state (Massachusetts) with a population of less than seven million (Patel et al., 2013). In South Africa, it has been estimated that for every 100 000 uninsured individuals accessing the public mental health sector, there are 0.31 psychiatrists, 0.91 psychologists, 1.53 occupational therapists, 1.07 speech therapists and audiologists, 1.83 social workers, and 27.3 specialist nurses (of which not all are psychiatric nurses) (Docrat et al., 2019). Consequently, there is a major imbalance in the need for mental health services and the available mental health professionals.

In sub-Saharan Africa, only 42% of countries have officially adopted a mental health policy with a median of 0.62% of the health budget being allocated to mental health (WHO, 2011). While South Africa, compared to other African countries, has taken some critical steps to strengthen the mental health system by developing policy and guidelines, little has come to fruition in practice (Docrat et al., 2019; Lund et al., 2012). South Africa’s public mental health expenditures only make up 5.0% of the total public mental health budget, of which more than half is spent at the level of psychiatric hospitals (Docrat et al., 2019). Furthermore, nearly a quarter of mental health in-patients are readmitted to hospital, costing the government 18.2% of the total mental health budget (Docrat et al., 2019). Although South Africa has made progress in providing mental health services, there remains room for improvement.

There is growing international consensus that a task-sharing approach is required to narrow the global treatment gap (Jack et al., 2020; Lund et al., 2015). According to this approach, mental health professionals train and supervise health workers to deliver mental health interventions (Lund et al., 2015). This approach would require the merging of mental healthcare into primary healthcare systems (Patel et al., 2013). Doing so would improve access to mental healthcare, provide more holistic patient-centred care by integrating physical and mental healthcare, and reduce stigma (Lund et al., 2015; Patel et al., 2013). Although the suggestion seems promising, there is limited research on the feasibility, acceptability, cost-effectiveness, and possible barriers to and facilitators of such interventions (Lund et al., 2015; Lund et al., 2020; Munodawafa et al., 2018).

Mental Health Service Use

The global mental health treatment gap may also be explained by the poor utilisation of available mental health services by those experiencing common mental health problems. (Roberts et al., 2018). Even with increased treatment coverage in HIC, treatment rates remain low (Jorm et al., 2017). Globally, it has been estimated that around 42–44% of individuals experiencing a common mental health problem seek mental health support from any form of professional service providers (Kohn et al., 2004). The treatment rates in LMICs have been estimated to be even lower, less than 5% in some countries (Wang et al., 2007).

In South Africa, individuals also show poor utilisation of readily available mental healthcare services. Only a quarter of adults experiencing a common mental health problem (anxiety, mood, and substance use disorders) receive some form of treatment (Herman et al., 2009; Seedat et al., 2009; Seedat et al., 2008). Among these individuals, treatment was received, in descending order, by general medical practitioners (16.6%), human services (6.6%), complementary and alternative medical providers (5.9%), psychiatrists (3.8%), and non-psychiatric mental health specialists (2.9%) (Seedat et al., 2008). Furthermore, individuals experiencing common mental health problems who are indeed accessing mental healthcare only received on average 4.6 treatment sessions over a 12-month period (Seedat et al., 2008). The low number of treatment sessions are less than sufficient for adequate treatment according to the guidelines for most mental health problems (American Psychiatric

Association, 2002, 2010a, 2010b). South Africans, therefore, receive far fewer treatments than the burden of mental health problems would require.

Mental Health of Children and Adolescents Globally and in South Africa

Addressing Child and Adolescent Mental Health

Mental health problems originating in childhood may have long-term consequences. It has been estimated that 50% of all life-time mental health problems start by the age of 14, with the onset of anxiety disorders starting as young as 11 years of age (Belfer, 2008; Kessler et al., 2005, 2007). Although not the focus of this review, the mechanisms by which children become at risk for the development of mental health problems vary and depend on multiple interacting genetic, family, and community factors (Mayberry et al., 2015). There is a strong relationship between poor mental health, other health and developmental concerns, including the risk of poor academic performance, interpersonal conflict, alcohol and drug abuse, aggressive behaviour, suicide, and legal transgressions (Patel et al., 2007; Suldo et al., 2014). If childhood mental health problems are left untreated, these problems may persist into adulthood with further consequences.

Childhood presents an opportune time to address the overall mental health burden. Preventing mental health problems during childhood could address the development of mental health problems in both childhood and adulthood, thereby reducing the overall burden of mental health problems (Patel & Rahman, 2015). Furthermore, mental health interventions aimed at CYP are generally low-cost and it is feasible to integrate them in existing community and school platforms, consequently making it a good option for the low-resourced communities typically found in LMICs (Patel & Rahman, 2015). It is therefore in the best interest of the global mental health agenda to focus its efforts on the prevention of mental health problems during childhood.

Although the last two decades have seen an increase in efforts to address mental health problems among CYP living in LMICs, there is room for improvement. It is estimated that 90% of the world's CYP are currently living in LMICs , while only 10% of all mental health randomised controlled trials (RCTs) are conducted for their benefit (Kieling et al., 2011). Furthermore, there are a variety of non-governmental organisations (NGOs) that provide mental health services beyond the overburdened public health system (Babatunde et al., 2020). However, NGOs are often 'overused' as a way to compensate for the lack of government-funded CAMH services (Mokitimi et al., 2019).

Epidemiological Data

Mental health problems among CYP constitute a major global issue. It has been estimated that one out of eight children and adolescents, globally, are directly affected by a mental health problem (Costello et al., 2003; Kieling et al., 2011; Polanczyk et al., 2015). CAMH has been ranked among the five largest contributors to DALYs in many areas worldwide (Baranne & Falissard, 2018). Although this is not currently true for African countries, a future increase in the prevalence of mental health problems is expected due to an *epidemiological transition*, meaning that the effect of mental health problems on DALYs will soon surpass that of non-communicable diseases (Baranne & Falissard, 2018). The current state of mental health problems in African countries may, therefore, be even more dire than represented by current statistics.

Research has shown that statistics on CAMH prevalence rates in LMICs may be underrepresented (Erskine et al., 2017; Kieling et al., 2011). Current epidemiological data suggest prevalence rates between 10 and 20% for LMICs, consistent with those found in HICs (Erskine et al., 2017). However, these findings are not necessarily representative of the reality, as the global coverage of CAMH prevalence rates has been estimated to be as low as 6.7%, with LMICs being especially underrepresented (Erskine et al., 2017). It is therefore possible that the prevalence of mental health problems among children in LMICs may be higher than previously thought.

Although epidemiological data on the prevalence of CAMH problems in South Africa are sparse, available data suggest high prevalence rates (Flisher et al., 2012; Kleintjes et al., 2010; Perold, 2001). Studies that have attempted to gauge these prevalence rates mostly include samples that are small and unrepresentative. These studies also often used measures that were not adequately adapted for its contexts (Flisher et al., 2012). Adjusting for these limitations, Kleintjes et al. (2006) conducted a systematic review and estimated a prevalence rate of 17% for children and adolescents, with the most common disorders being generalised anxiety disorder (11%), followed by post-traumatic stress disorder (PTSD) and major depressive disorder/dysthymia (both at 8%). Perold (2001), however, reported higher rates of anxiety disorders (22–25.6%) among 7- to 13-year-old children in the Western Cape. Although tentative, available South African data may indicate a prevalence rate higher than the global average for CAMH problems.

Risk Factors and Protective Factors

South African children may be disproportionately at risk of developing mental health disorders due to their continuous exposure to multiple environmental and contextual risk factors, including HIV/AIDS, poly-victimisation, and poverty (Kieling et al., 2011; Lund et al., 2011; Patel et al., 2010; Skeen et al., 2019).

HIV/AIDS. HIV/AIDS has been strongly associated with poor mental health outcomes for CYP in South Africa. It has been estimated that around 88% of the 2.7 million CYP (0-19 years old) living with HIV/AIDS, live in sub-Saharan Africa and 520 000 in South Africa (UNICEF, 2021). There is a lack of information on the mental health of CYP living with HIV, but the little that is available shows a high prevalence of depression, with rates being as high as 81% in some samples (Arseniou et al., 2014). This trend continues among AIDS-orphaned CYP, whose prevalence of depression and PTSD are significantly higher than CYP orphaned by other causes (Cluver et al., 2012; Kumar et al., 2014). Perinatally HIV-infected CYP also tend to show high prevalence of common mental health disorders (Lowenthal, 2014), which may lead to poor adherence to medication and risky sexual behaviour, ultimately increasing the risk of secondary infections (Woollett et al., 2017). Indeed, a recent study demonstrated the bidirectional relationship between HIV and mental health problems, (Kinyanda et al., 2018). The occurrence of HIV/AIDS may therefore have both direct and indirect consequences for the mental health of CYP in South Africa.

Certain risk and protective factors have been identified that mediate the consequences of HIV/AIDS on the mental health of CYP, including bullying, self-efficacy, and parenting. A recent study by Boyes et al. (2019) showed that emotional abuse and bully victimisation are strongly associated with worse mental health outcomes among CYP living with HIV/AIDS, while positive parenting and self-efficacy are associated with better mental health outcomes. Bullying, self-efficacy and parenting may therefore be salient intervention targets (Boyes et al., 2019). The resilience of children bereaved by HIV/AIDS may best be addressed by a focus on physical health, caregiving quality, food security, peer relationships, mitigating exposure to violence, and reducing stigma (Collishaw et al., 2016).

Poly-victimisation. There is growing recognition that South African children experience multiple forms of victimisation (poly-victimisation). These victimisation types are often interconnected, with one breeding susceptibility to other forms of victimisation, which may also occur across different contexts (Leoschut & Kafaar, 2017). Poly-victimisation and cumulative exposure to violence are associated with an increased risk of developing mental health problems (Pengpid & Peltzer, 2021; Rapsey et al., 2019).

Violence and crime are common occurrences for South African children (41.4%), with such violence occurring at home in 21.8% of cases (Leoschut & Burton, 2006). In one area of Cape Town, the exposure to violence was shown to be as high as 98.7% for community violence, 76.9% for domestic violence, and 75.8% for school violence (Kaminer et al., 2013). As high as 93.1% of CYP have been exposed to one or more types of violence and more than half of the CYP have been exposed to a minimum of four types of violence (Kaminer et al., 2013).

Children in South Africa also experience high levels of maltreatment with a lifetime prevalence rate of 55% for physical abuse, 36% of emotional abuse (Meinck et al., 2016), and with 35.4% being sexually victimised by the age of 17 (Artz et al., 2016). In one study, 20.8% of children reported being physically abused by a parent or caregiver (Artz et al., 2016). Similarly, 58% of parents have reported using physical force against their children and in 33% of cases doing so with the use of an object (Dawes et al., 2005).

A number of risk and protective factors for poly-victimisation have been identified. Risk factors may include household structure (child-headed, extended family composition), frequent exposure to domestic violence, living in a disorganised community, inconsistent parenting, poor parental supervision, parental absence, and parental substance abuse (Artz et al., 2016), as well as poverty and AIDS-related stigma (Meinck et al., 2015). Social support may be a key protective factor against the consequences of poly-victimisation. A comprehensive review of the protective factors for poly-victimisation has shown support from family members to be a protective stabilising factor against the development of mental health problems among CYP (Ozer et al., 2017). However, in South Africa, the variable family structures and compositions and exposure to multiple adversities may undermine the effects of family support (Humm et al., 2018). Indeed, with limited South African research on this topic, there is no consensus on the effect of social support (Humm et al., 2018).

Poverty. Poverty often plays a mediating role in children's risk of developing mental health problems. For instance, a study by Meinck et al. (2017) found that families who suffer from financial and health disadvantages often have abusive parenting and parental mental health problems. In turn, abusive parenting and the mental health problems of caregivers increase the health risks of CYP. Poverty can also undermine parenting as parents living in poverty are usually poorly educated and have little financial resources to support the educational and nutritional needs of their children (Ward et al., 2015). Unmet educational and nutritional needs often have consequences for children’s chances at a fulfilling life, thereby contributing towards an intergenerational cycle. The effects of poverty may also be further exacerbated by family structures such as single parenting and/or absent father figures, since this may increase challenges for the caregiver responsible for the child (Ward et al., 2015). Poverty is thus not directly linked to the occurrence of mental health problems, but often creates a fertile environment for other risk factors.

CYP in South Africa are thus disproportionately at risk of developing mental health problems due to their exposure to multiple risk factors. Mental health problems may persist into adulthood if there is no appropriate intervention. Seeking appropriate help for mental health problems during childhood and adolescence might thus be an essential step in promoting mental health among adults.

Caregiver Involvement in Help-Seeking for their Children

Help-seeking is an important process in accessing appropriate mental health care for children experiencing mental health problems. However, CYP often avoid or delay seeking help for their problems (Essau, 2005; Merikangas et al., 2011; Xu et al., 2018). Furthermore, interventions to promote mental health help-seeking seems to have little to no effect on CYP. For example, a systematic review and meta-analysis conducted by Xu et al. (2018) found that although help-seeking interventions showed improved formal help-seeking (engaging with mental health professionals) among individuals living with or who are at risk of mental health problems, it had no effect on mental health help-seeking among children, adolescents or the general public. CYP may be reluctant to engage with CAMHS on their own.

CYPs rely and depend on their caregivers for mental health support and accessing mental health services (Hassett et al., 2018). Even if the CYP are in the phase of developing independence, caregivers remain the most influential source of support in securing mental healthcare for their children (Gulliver et al., 2010; Wahlin & Deane, 2012). CYP require the assistance of a caregiver to navigate the help-seeking process on their behalf, considering that they do not have the means to independently seek help (Boulter & Rickwood, 2013). Furthermore, caregivers are usually the first to recognise when their children are experiencing mental health problems, putting them in the best position to initiate the help-seeking process (Hurley et al., 2020). Help-seeking for CYP experiencing a mental health problem is thus highly dependent on the caregivers' ability to facilitate the process.

Although caregivers have the potential to play a key role in the help-seeking process on behalf of their children, they experience a plethora of barriers that influence their ability to act as agents. In addition to broader systemic difficulties in accessing available mental health services, caregivers may also have beliefs, experiences, and knowledge that may complicate the help-seeking process (Hurley et al., 2020; Reardon et al., 2017, 2020; Sarikhani et al., 2020). However, there are also things that facilitate their ability to act as agents. In the section that follows, I provide an overview of the barriers and facilitators caregivers may encounter in accessing the available mental health care, including those related to service provision and utilisation, cultural beliefs and attitudes, mental health literacy, and support networks.

Service Provision and Utilisation

Although limited, the available evidence suggests that there is poor mental healthcare provision for CYP in LMICs. Indeed, the median one-year treated prevalence for children and adolescents have been estimated to be 159 per 100 000 compared to the 664 per 100 000 among adults (Morris et al., 2011). Furthermore, CYP in outpatient facilities and other facilities only make up 12% and 6% of the patient population, respectively, with less than 1% of inpatient facility beds being reserved for children and adolescents (Morris et al., 2011). To my knowledge, no data exist for the use of mental health services among South African CYP.

Mental Health Policy and Legislation. CAMH has slowly become an international priority as exemplified in the focus on mental health in the sustainable development goals set by the United Nations in 2015 (Votruba & Thornicroft, 2016). The sustainable development goals point out, among other things, the importance of promoting mental health through prevention and intervention and universal health coverage (Schneider et al., 2016). The plan to reach these goals starts with sound policy and service delivery models (Mokitimi et al., 2018). However, there are still short-comings with respect to policy development and implementation for CAMH in South Africa (Mokitimi et al., 2018; Schneider et al., 2016). The last situational analysis of CAMHS conducted by Kleintjes et al. (2010) identified that South Africa does have mental health policy guidelines, a stand-alone CAMH policy, and mental health legislation at a national level. However, despite the efforts to address the burden of mental health problems in South Africa, these pieces of legislations and policies have resulted in very little practical change (Lund et al., 2012; Schneider et al., 2016).

The Mental Health Policy Guidelines (Department of Health, 1997) propose the development of mental health services and its integration into health care system on all governmental and community levels. The implementation of these guidelines were, however, not prioritised, most likely due to poor communication between various levels of the health system (Draper et al., 2009), a lack of human and financial resources, limited evidence-based treatment protocols, the low priority of mental health, stigma, and feasibility and sustainability issues (Schneider et al., 2016). Since 1997, these policy guidelines have been formally adopted into the National Mental Health Policy Framework and Strategic Plan 2013–2020 (Department of Health, 2014), aimed at realising the integration of mental healthcare into a comprehensive healthcare as described in the Mental Health Care Act, 17 of 2002 (“the Act”) (Department of Health, 2004).

The Act (Department of Health, 2004) provides for the care, treatment and rehabilitation of those who are mentally ill and aims to decentralise mental healthcare (Petersen & Lund, 2011; Ramlall et al., 2010). The Act also introduced Mental Health Review Boards with the sole purpose of upholding the human rights and health rights of those who live with a mental health problem or intellectual disability (Department of Health, 2004). Evidence shows that the act has led to some progress with the decentralisation of mental healthcare by making psychotropic medication more readily available and limiting psychiatric hospital beds (Petersen & Lund, 2011). However, there has been poor development of infrastructure, community-based services, and training of specialist staff to support the deinstitutionalisation (Petersen & Lund, 2011). These remaining challenges place further pressure on an already overburdened healthcare system which may, in turn, lead to the very human right violations the Act aims to prevent (Petersen & Lund, 2011).

Despite increased awareness of and attempts to address mental health problems in South Africa, policies and legislation up until 2002 did not adequately address the needs of CAMH (Mokitimi et al., 2018). Although the Mental Health Policy Guidelines (1997) expressed the sentiment of the high priority of CAMH, no clear guidelines were identified to address CAMH issues. The Act did not specifically provide for children and adolescents, only addressing one of six provisions for the protection of minors recommended by WHO (2017). Although not specifically addressing CAMHS, the Children’s Act, 38 of 2005 (Department of Health, 2004), has some implications for the services available to vulnerable children and adolescents (Dawes, 2009).

In 2003, the South African government commissioned a research project aimed at establishing norms and standards for the development of accessible CAMHS (Dawes et al., 1997, 2004; Crick Lund et al., 2009). Based on this work, the National Child and Adolescent Mental Health Policy Framework (2003) was formulated. This framework provides a scaffold for staffing levels, division of services and facilities, and steering new developments. Evidence indicates, however, that none of the provinces have developed a provincial CAMH policy or implemented plans to support the national CAMH policy (Mokitimi et al., 2018). It is clear from these findings that CAMH remains a neglected area of concern at both the policy and legislation level, as well as its implementation, despite the well-recognised burden of CAMH problems in South Africa.

The poor implementation of legislation and policies and the neglect of CAMH issues have contributed to a national system that does not adequately address the growing burden of CAMH problems in South Africa. Caregivers may, therefore, have trouble navigating and using a system that is not capable of supporting children experiencing mental health problems.

Financial and Logistical Issues. The costs of mental health services has been identified as a major financial barrier to accessing available CAMHS (Reardon et al., 2017; Sarikhani et al., 2020). Even in LMICs where there are suitable and available services, these services have not proven affordable for many patients and their families (Sarikhani et al., 2020). Furthermore, limited and costly insurance coverage hinders equitable access to mental health services (Sarikhani et al., 2020). Indeed, a crude estimate indicates that only 0.89% and 7.5% of uninsured South Africans needing mental healthcare received public inpatient and outpatient care respectively (Docrat et al., 2019). The exorbitant cost of mental health services leaves many caregivers financially unable to access help for their children experiencing mental health problems.

Although not as salient as the costs of mental health services, caregivers have cited other logistical and financial barriers in accessing mental health services (Hansen et al., 2021; Reardon et al., 2017; Sarikhani et al., 2020). Inconvenient appointment times for services, transportation (time and costs), inappropriate location of mental health services, complicated administrative systems, long waiting periods, and the potential loss of wages have all been mentioned as minor inconveniences in the process of seeking help for children's mental health problems (Hansen et al., 2021; Reardon et al., 2017).

Cultural Beliefs and Attitudes

Caregivers' cultural beliefs and attitudes towards CAMHS is another major barrier/facilitator in caregivers' willingness to access mental health services on behalf of their children. Therapeutic relationships with and preferences regarding mental healthcare providers, beliefs regarding therapeutic outcomes, and stigma all influence caregivers' willingness to engage with CAMHS (Hurley et al., 2020; Reardon et al., 2017; Sarikhani et al., 2020).

The Therapeutic Relationship. In HICs, caregivers place significant emphasis on the quality of the relationship with mental health care providers (Hurley et al., 2020; Reardon et al., 2017). Caregivers have indicated that trust, collaboration, and confidence in the abilities of the mental healthcare providers are paramount in their relationship with CAMH providers. In contrast, feelings of not being heard, negative behaviour and attitudes, as well as dismissal and blame from CAMH providers were seen as factors negatively influencing the therapeutic relationship (Hansen et al., 2021; Reardon et al., 2017).

Fearing negative therapeutic relationships, caregivers may opt to deal with children's mental health problems without professional guidance. Caregivers who have had previous negative experiences with CAMH may wish to rather deal with mental health problems in the family context rather than seek professional support (Reardon et al., 2017). Indeed, a sample of English caregivers reported that they wish to manage their children's anxiety at home as they believe the problem could improve without professional help (Reardon et al., 2020). Negative expectations with regards to the therapeutic relationship therefore deter many caregivers in seeking help.

In contrast, a good therapeutic relationship between caregiver and CAMH provider may have positive implications for the help-seeking process. Caregivers who experience greater shared decision making between caregiver and CAMH provider have greater satisfaction with care (Butler et al., 2015). Furthermore, caregivers who perceive that CAMH professionals listen to their voiced concerns are more willing to engage with the help-seeking process (Hansen et al., 2021; Reardon et al., 2017). Good therapeutic relationships are thus essential in facilitating caregivers' involvement in the help-seeking process.

In LMICs, very little is known about the preferences caregivers may have regarding their therapeutic relationship with CAMHS providers. Among the general adult population, individuals have been shown to prefer alternative mental health care, such as traditional healers and spiritual/religious leaders (Sarikhani et al., 2020). Indeed, a large number of South Africans prefer complementary mental health services, considering that traditional healers often provide culturally appropriate care. They have a positive effects on community mental health and are more easily accessible (Campbell-Hall et al., 2010). Even though the preference for traditional healers and spiritual/religious leaders may steer individuals away from formal mental health services, acknowledging and developing the former as a legitimate resource of support may support task-sharing in improving the treatment gap typically found in LMICs (Pham et al., 2021). However, more research is needed to determine the beliefs and attitudes of specifically caregivers living in LMICs like South Africa and how this may influence the help-seeking process for their children in these contexts.

Consequences of Therapeutic Outcomes. Caregivers are often concerned over the consequences and relevance/effectiveness of treatments (Crouch et al., 2019; Reardon et al., 2017). Individuals who doubt the outcomes of treatments are less likely to engage with mental health services for their children (Reardon et al., 2017). In LMICs, the general adult population is often concerned about the possible side-effects of medicine and technology-based interventions and fear long-term hospitalisation, repeated consultations, and delayed treatment outcomes (Sarikhani et al., 2020). Patients who believe that treatments are merely there to control behaviours rather than treating the problem, may have little adherence to further treatment (Sarikhani et al., 2020). Although the beliefs surrounding therapeutic outcomes may be a barrier to the general population living in LMICs, it remains uncertain how such beliefs may influence caregivers from these contexts.

Stigma. Fear of stigma from others often deters caregivers from accessing mental health services on behalf of their children (Crouch et al., 2019; Reardon et al., 2017). Caregivers have reported being concerned that a formal diagnosis would “follow the child” (Ofonedu et al., 2017, p. 871), ultimately leading to unwanted consequences later in life (Hansen et al., 2021; Ofonedu et al., 2017). For instance, caregivers fear that children, having received a diagnosis, would be treated differently by others (Ohan et al., 2015). Caregivers are concerned that labelling children with a mental health problem would lead to stigma and discrimination.

Caregivers may also self-stigmatise and feel embarrassed to seek help for their children. They often feel a sense of failure and self-blame when their children experience mental health problems and find it difficult to talk about their children’s mental health problems (Hansen et al., 2021; Reardon et al., 2017, 2020). They perceive the act of seeking help for their children as an admission of failure to adequately raise and support their children. However, no matter the motivation, both self-stigma and stigma from others motivate caregivers to solve mental health problems in the family context rather than seeking professional help (Reardon et al., 2017). It is unclear, however, how stigma influences the help-seeking process of caregivers living in South Africa.

Mental Health Literacy

Caregivers' mental health literacy concerning CAMH could potentially have a major impact on their willingness to engage with CAMHS (Reardon et al., 2017). According to Jorm et al. (1997) mental health literacy involves knowledge about (1) the prevention of mental health problems, (2) the recognition of mental health problems, (3) the process of help-seeking and options for treatment, (4) dealing with "less serious" emotional and mental health problems (self-help), and (5) supporting an individual experiencing a mental health problem (Jorm, 2012). Therefore, mental health literacy directly applies to a caregiver's ability to recognise, understand, and appropriately respond to children's mental health problems.

Current State of Child Mental Health Literacy. Although research on the matter of child mental health literacy is limited, evidence to date suggests that CAMH problems are poorly recognised and understood in the general global population (Tully et al., 2019). For example, a recent systematic review investigated the current global body of research (up until January 2018) on parent and caregiver mental health literacy (Hurley et al., 2020). The authors identified 21 eligible studies (both qualitative and quantitative) across six countries (Australia, United States, United Kingdom, Canada, Malaysia). Upon completing a narrative synthesis of the study results, the authors concluded that parents exhibited poor mental health knowledge across all studies (Hurley et al., 2020). In the most recent studies, a sample of El Salvadorian parents (N=127) correctly identified common childhood mental health problems depicted in vignettes for Separation Anxiety Disorder (9.6%), Social Anxiety Disorder (4.4%), and Generalised Anxiety disorder (0.4%). Although 23–39% of parents were able to identify the scenario as depicting some form of anxiety, less than 5% of parents recognised the anxiety disorders as a mental health problem, preferring to ascribe the anxiety to personal weakness and stress (Johnco et al., 2019). Similarly, a sample of Cambodian and Vietnamese mothers showed poor mental health literacy by correctly identifying common child mental health problems only 17–35% of the time (Dang et al., 2021). Studies seem to conclude that caregivers struggle to recognise mental health problems in their children.

In South Africa, the little research available on mental health literacy has indicated similar poor levels in the wider adult population (Hugo et al., 2003; Kometsi et al., 2020). Other studies conducted on specific target groups, for example pregnant women (Spedding et al., 2018), healthcare workers (Hooblaul et al., 2020; Mohamed-Kaloo & Laher, 2014), traditional healers (Sorsdahl et al., 2010), university students (Petersen, 2019; Zita, 2018), and individuals living with HIV/AIDS (Sorsdahl et al., 2010), have shown similar outcomes. Current literature may indicate that South Africans have poor mental health literacy. To my knowledge, no such research is available on South African caregivers' mental health literacy, specifically regarding CAMH.

Despite the reported poor mental health literacy among South Africans, they may have valuable knowledge about mental health. Jorm's definition of mental health literacy implies knowledge of evidence-based mental health problems and their treatment (Jorm et al., 1997). Consequently, being mental health illiterate means that one has little or no evidence-based knowledge, i.e. knowledge on current research. What this definition may fail to incorporate is that although an individual may be, by Jorm's definition "mental health illiterate", such individuals may still have knowledge about mental health derived from other sources, including cultural and personal beliefs (Andersen et al., 2015; Desai & Chaturvedi, 2017; Ganasen et al., 2008; Mayston et al., 2020).

Recognising Mental Health Problems. Caregivers' potential to act as an agent in help-seeking for their child's mental health problem is highly dependent on their ability to recognise their child's mental health problem (Hurley et al., 2020; Skylstad et al., 2019). Caregivers' recognition of CAMH problems is often influenced by the nature, severity, and timing of symptoms, personal experiences with mental health problems, as well as cultural norms.

Mental health illiteracy (according to Jorm's definition) may be problematic during communication between caregivers and mental healthcare professionals. Communication between caregivers and mental healthcare professionals may be laboured if caregivers have difficulty communicating mental health problems and recognising specific psychiatric labels (Furnham & Swami, 2018). Furthermore, mental healthcare professionals may not be versed in the various idioms of distress and contextual and cultural factors that inform their patients'/clients' understanding and expression of mental health problems (Furnham & Swami, 2018). This miscommunication and misunderstanding between caregivers and mental healthcare professionals may negatively affect the help-seeking process.

Caregivers' ability to recognise mental health problems is also influenced by the nature of the mental health problem (Hurley et al., 2020; Skylstad et al., 2019). Visible abnormal behaviour, such as tantrums, undressing in public, an inability to control oneself, and rudeness are considered "crazy" behaviour, which is in breach of the accepted standard and is thus more easily recognised as a mental health problem (Lichtenberg et al., 2021; Skylstad et al., 2019). According to Skylstad et al. (2019) the "softer" (p. 8) symptoms associated with depression, which are often exaggerated forms of acceptable behaviour, such as "thinking too much" (p. 8), is often recognised as a problem, but not necessarily recognised as a mental health problem. Consequently, externalising symptoms, as opposed to internalising symptoms, may make it easier for caregivers to recognise mental health problems in their children.

The severity of the symptoms associated with mental health problems also influences the ability of caregivers to recognise mental health problems and act accordingly. Caregivers struggle to distinguish between normal child difficulties and mental health problems, lacking the confidence to judge whether their child's anxiety is "normal" (Hansen et al., 2021; Reardon et al., 2017, 2020). Engaging with the help-seeking process is also further complicated by a discrepancy between caregiver and child regarding the severity of the symptoms and the associated impact on quality of life, with similar perceptions contributing to a more collaborative help-seeking approach (Hassett et al., 2018). Consequently, perceptions of symptom severity by both caregiver and CYP influence the judgement on whether professional help is required.

The nature and timing of the presenting symptoms further confound caregivers' ability to recognise mental health problems in their children (Reardon et al., 2020). Caregivers have indicated that their children's anxiety symptoms often come and go, making it difficult to track symptoms over time and recognise when help is needed. However, a sudden and severe change in behaviour or persistent symptomatology is often easier recognised (Boulter & Rickwood, 2013; Reardon et al., 2017, 2020).

Although evidence has shown that caregivers' experiences with their own mental health problems may influence their recognition of their child's mental health problem, there are discrepancies in the literature regarding the exact role it plays (Reardon et al., 2018). In Reardon et al (2018), parental anxiety sometimes helped parents recognise similar symptoms in their children. At other times, parents living with anxiety were concerned about being oversensitive or overprotective, consequently hindering their ability to recognise the symptoms of anxiety in their children. Parental mental health problems can therefore act either as a barrier or a facilitator in the help-seeking process.

The unique way in which a child expresses symptoms may also hinder a caregiver's ability to recognise these symptoms as a mental health problem. Individuals may make use of alternative ways of expressing distress (idioms of distress), or symptoms of mental health problems that conforms to their personal and cultural norms (Desai & Chaturvedi, 2017). For example, idioms of distress are often presented as physical symptoms, such as muscle weakness, pain, and weight changes (Lichtenberg et al., 2021). These may be ascribed to a physical problem rather than a mental health problem. If a caregiver is unaware of a child's idioms of distress, they may wrongly identify the problem their child is experiencing.

Understanding Mental Health Problems. Caregivers from different cultural contexts may make use of different or multiple explanatory models to conceptualise the possible causes of various mental health problems (Kometsi et al., 2020). Firstly, caregivers may ascribe the source of mental health problems to religious, indigenous, or spiritual sources. For instance, a sample of Ugandan parents believe that supernatural causes, such as attacks by demons/spirits and spells cast through witchcraft or the naming of a child may affect the child later in life (Skylstad et al., 2019). A sample of South African parents believe that the symptoms associated with schizophrenia could be explained by bewitchment or *ukuthwasa* (a calling to become a traditional healer) (Kometsi et al., 2020).

Secondly, caregivers may prescribe to psycho-social explanatory models in their explanation of mental health problems. In a recent study, a sample of Haitian parents explained that, besides spiritual and religious causes, mental health problems can be caused by poverty, experiencing traumatic events, and ruminating on problems (Lichtenberg et al., 2021). Additionally, a sample of Ugandan parents explained that "ruining" or "spoiling" a child by harsh punishment or lack of care causes the child to become stubborn and turn away from home. Furthermore, the use of substances, such as alcohol, will cause or worsen the symptoms of mental health problems (Skylstad et al., 2019). A sample of El Salvadorian parents showed a poor understanding of the aetiology and symptoms of anxiety disorders, often siting personal weakness as the cause of anxiety disorders (Johnco et al., 2019).

Lastly, although more rarely cited, caregivers may opt for a bio-medical understanding of the cause of mental health problems. A sample of Ugandan parents explained that medication, illness, amount of blood in the body, and the arrangement of “wires” (neurons) might disrupt the “healthy/balanced” brain, causing symptoms associated with mental health problems (Skylstad et al., 2019). Among South Africans, individuals conceptualised depression in medical terms (Kometsi et al., 2020).

The varied models of explaining mental health problems may indicate that caregivers are embracing both Western (medical and psycho-social models) and indigenous beliefs (ancestral beliefs, bewitchment, etc.). However, the specific understandings of mental health problems may vary from community to community and even among individuals in a community. It is therefore important to understand and respect the various belief systems with regard to the aetiology of mental health problems to promote communication between caregiver and mental healthcare professionals.

Responding to Mental Health Problems. Poor knowledge or understanding of the help-seeking process may make it difficult for caregivers to access the available mental health services. Caregivers may feel unsure about who to contact for help and what sources of help are available for their children’s mental health needs (Hansen et al., 2021; Reardon et al., 2017, 2018, 2020).

Caregivers from different contexts may have differing preferences with respect to sources of support for their child’s mental health problem. In some studies, typically conducted in HIC, caregivers endorsed seeking help from various professionals, including (in descending order of popularity) general practitioners, school mental health services, counsellors, psychologists, and psychiatrists (Hurley et al., 2020; Ohan et al., 2015). Dealing with mental health problems in the family without seeking help from outside, was often regarded as negative or harmful for the child who is experiencing a mental health problem (Hurley et al., 2020).

In contrast, caregivers and individuals living in LMICs often prefer dealing with their own and their children's mental health problems themselves rather than seeking help from mental health professionals (Hugo et al., 2003; Johnco et al., 2019; Sarikhani et al., 2020). Although these individuals are generally not averse to receiving help from mental healthcare professionals, they prefer dealing with their children's mental health problems in the family context (Hugo et al., 2003; Johnco et al., 2019; Sarikhani et al., 2020). However, having a preference requires the availability of multiple choices. In the low-resourced context often found in LMICs, caregivers may not have the luxury of choice when it comes to help, forcing them to rely on their own familial resources. However, the exact relationship between poor mental health resources and preferences for ways to deal with mental health problems requires further examination.

In some communities, there may be an interplay between different sources of support. For a sample of Ugandan parents, dealing with mental health problems means dealing with the underlying traditional causes of mental health problems, including spirits, spells, and demons (Skylstad et al., 2019). Elders, religious leaders, traditional healers, and witchdoctors are often consulted to deal with such matters. Health facilities are then expected to examine patients, give advice, and provide medicines and injections to "calm the patient down" (p. 7), thus making patients more cooperative during treatment by religious leaders (Skylstad et al., 2019). In such cases, health facilities and traditional healers are expected to work together to support a child experiencing mental health problems.

Caregivers’ lack of confidence in responding to their children’s mental health problems influences if and how they engage with mental healthcare professionals. Caregivers who feel incompetent when providing their children with the necessary support are more likely to seek additional input and help from professionals (Reardon et al., 2018). However, caregivers’ perceptions of the anticipated response from professional might influence their decision to contact a mental healthcare professional (Reardon et al., 2018). Even when a choice has been made, caregivers may feel less confident in their choices simply because they initially did not know what to do (Honey et al., 2015). Several steps in responding to a child’s mental health problems, i.e. identifying the need for additional support, engaging with support, and reflection on the choices made, can be curtailed by parental doubt.

There is some evidence to suggest that caregivers’ ability to provide support for children experiencing mental health problems is strongly influenced by the amount of time they spend with their children (Honey et al., 2015). On the one hand, not spending regular time with children limits caregivers’ interactions with their children as well as the type and amount of support they can offer to their children. On the other hand, strategic times away from children are useful for caregivers’ ongoing coping and decision making on appropriate support for their children (Honey et al., 2015). Balancing time spent with children is therefore key in providing parental support to children.

Caregivers who are able to be constantly available to their children were more likely to feel confident in acting as facilitator in the help-seeking process (Hassett et al., 2018). Caregiver availability refers to several factors, including sensitivity (reacting to children’s emotional and physical needs), structuring (supporting without removing autonomy), non-intrusiveness and non-hostility, as well as the way in which caregivers express their emotions to their children and understand their child’s emotions (Hassett et al., 2018). Consistent caregiver availability is thus crucial in caregivers’ ability to support and seek help for a child experiencing mental health problems.

Parenting styles and characteristics and the child-caregiver relationship may also contribute to a caregiver’s ability to support a child experiencing mental health problems (Baumrind, 1971). Parental authoritativeness and social support for children experiencing mental health problems have been strongly associated with intentions for help-seeking (Maiuolo et al., 2019). Personal characteristics, such as strength, determination, patience and own emotional vulnerability may also influence caregivers’ ability to support and maintain such support over time (Honey et al., 2015). The success of caregiver support is also dependent on the child-caregiver relationship. Struggling relationships often lead to children rejecting caregiver help and support, which may leave caregivers feeling helpless and looking to others to help (Honey et al., 2015). Caregiver characteristics and their relationship with their child thus contributes to the quality of support they may have to offer a child in distress.

Support Networks

Caregivers may reach out to various individuals in their support network, including friends, family, colleagues, and teachers for support in dealing with their child’s mental health problem (Hurley et al., 2020). Generally, caregivers have reported that they find it acceptable and helpful (for both caregiver and child) to engage with their support networks for advice and informal support (Hurley et al., 2020). Caregivers may engage with different individuals in their support network for different benefits. For instance, caregivers often rely on educators for advice, information, and co-parenting when dealing with mental health problems or behavioural problems among children (Honey et al., 2015; Skylstad et al., 2019). A sample of Ugandan parents reported seeking information from educators on how to address behaviour problems in their children, relying on them to observe and discipline (often through corporal punishment) their children. Furthermore, educators are often consulted before seeking help from a help provider (Skylstad et al., 2019). However, some studies have shown that despite the significant role educators could play in identifying mental health problems in children, they might struggle to do so (Loades & Mastroyannopoulou, 2010; Skinner et al., 2019). Educators might benefit from further training to refine their ability to assist caregivers in the help-seeking process by recognising problems, facilitating contact with mental healthcare professionals, and offering support in the school context.

Support networks can provide caregivers with multiple forms of assistance and support. Emotional support from others, even just someone listening to them, benefit caregivers in coping and dealing with their own emotions regarding their child's mental health problem (Honey et al., 2015). Furthermore, in LMICs, individuals express the major role support networks play with respect to financial and physical assistance (Sarikhani et al., 2020; Skylstad et al., 2019). Additional financial and physical assistance is important considering that home and work responsibilities often make it difficult for parents to commit to the help-seeking process (Reardon et al., 2017; Sarikhani et al., 2020). With an extended support network, caregivers may be able to harness emotional, financial, and physical assistance to support them during the help-seeking process.

The attitude of the individuals in a caregiver's support network may also affect their confidence in their strategies and ability to take on a positive attitude to their child's future (Honey et al., 2015). For instance, mental healthcare workers can develop the competence of caregivers by teaching skills, providing advice and support when needed, and displaying confidence and optimism. A supportive social network can aid caregivers in the implementation of their response strategies, thereby ensuring the child receives a consistent message, rather than undermining the caregivers' efforts (Honey et al., 2015). Caregivers who have similar situations and experiences may also aid others in their help-seeking process by providing reassurance, advice, and support (Crouch et al., 2019; Honey et al., 2015; Hurley et al., 2021).

The structure of the larger community beyond caregivers' close support network may also influence their ability to recognise and respond to a child's mental health problem. A sample of Ugandan parents noticed a shift from a more traditional community handling of children to a more individualistic approach exclusive to the nuclear family (Skylstad et al., 2019). Where before it was expected of community members to share observations and advice, it is now considered an unwanted interference (Skylstad et al., 2019). The shift away from more traditional community involvement further complicates structural barriers to help-seeking, considering the lack of practical community support. A loss in collective community responsibility may hamper caregivers' ability to recognise and deal with mental health problems in their children.

This loss of collective community responsibility may also make it difficult for CYP to reach out to an adult for support. CYP often turn to other adults when their caregivers are not emotionally available to them. Such CYP often rely on the ability of other adults to notice the problem or to confide in (Hassett et al., 2018). When there is a lack of community support and observation and advice is unwanted, CYP experiencing mental health problems could be left without adult support altogether.

Caregivers may still feel the burden of responsibility despite support from their support network. They may still feel the burden of decision making as they are the individuals ultimately responsible for the wellbeing of the child (Honey et al., 2015). This burden may especially be difficult to bear when a caregiver has no one to share the responsibility as in the case of a single parent or absent parental figure. This burden may be lighter when such responsibilities and duties are shared among the caregivers of the child, or between a caregiver and mental healthcare worker (Honey et al., 2015). Single caregivers may therefore experience an increased burden of responsibility compared to nuclear families.

Caregiver Involvement in Child and Adolescent Mental Health Interventions

Based on what has been presented in this literature review up to now, it is clear that caregivers require support for their involvement with their children's MH and MHS, Specifically, it is clear that caregivers require and could benefit from support in recognising, understanding, appropriately responding to, and supporting their children's mental health problems. As such, interventions to support these aspects aimed at parents are necessary and important,

However, in LMICs, little has been done to provide support to caregivers and families experiencing mental health problems. A recent systematic review (Pedersen et al., 2019) seeking programmes and interventions conducted in LMICs between the years 1967 and 2017, identified a mere 32 parent- and family-focused studies across 23 countries. Furthermore, these studies were generally of poor quality and rigour, contained small sample sizes, and had several risks of bias throughout (Pedersen et al., 2019). The included studies were also selective in their approach. This means that the intervention strategies were targeted at subpopulations at high risk for developing mental health problems (O'Connell et al., 2009). For example, some studies focused on communities affected by armed conflict, high rates of violence, and HIV/AIDS (Pedersen et al., 2019). Consequently, there are little to no interventions aimed at promoting the general mental wellbeing of CYP and their families in the context of LMICs.

Although targeted approaches in CAMH intervention have shown promising results, they are resource-intensive and might be challenging to deliver at scale in LMICs (Kieling et al., 2011). As an alternative, universally delivered interventions have been shown to be a practical, feasible, effective, and scalable approach to delivering mental health interventions in HICs (Fazel et al., 2014; Paulus et al., 2016). Universal interventions include strategies that are offered to a whole population (O’Connell et al., 2009). Schools are also convenient locations for delivering mental health programmes due to the increased access to CYP and their families (Kern et al., 2017). Indeed, a review by Barry et al. (2013) on the effectiveness of universal school-based interventions in LMICs reported that such intervention can have positive mental health outcomes for CYP living in LMICs.

Despite the appeal of using universal school-based mental health programmes in LMICs, the efficacy and implementation of mental health programmes are often hindered by the lack of caregiver involvement (Gondek et al., 2017; A. K. Langley et al., 2010; Santiago et al., 2013; Weist et al., 2014). According to Haine-Schlagel and Walsh (2015) caregiver involvement is crucial to the success of CAMH interventions as (1) family significantly influences the development and behaviour of CYP, (2) caregivers are key gatekeepers in their children’s access to CAMHS, and (3) caregivers play a role in the reinforcement of the intervention content by providing support, completing home action plans, and practicing these skills in daily life. Furthermore, child and caregiver behaviour has a reciprocal or bidirectional effect on one another’s mental wellbeing (Burke et al., 2008; Serbin et al., 2015; Sifaki et al., 2020). Consequently, by only targeting caregivers or CYP, mental health interventions run the risk of undermining the intervention content, as unhelpful coping strategies continue to be modelled or maintained at home. Indeed, family-based interventions, as opposed to individualised interventions, have also been shown to reduce long-term mental health symptoms in both parents and children (Burn et al., 2019; Poole et al., 2018; Yap et al., 2016).

Although there are clear benefits to involving caregivers in CAMH interventions, very few studies conducted in LMICs do so. A recent narrative review by Bradshaw et al. (2020) on universal school-based mental health programmes in LMICs found that none of the 12 included studies involved caregivers directly, while four studies provided caregivers with information sessions and/or sheets. However, in the formative work in developing a universal school-based psychoeducational programme for CYP in South Africa, Coetzee et al. (2021) found that all stakeholders (teachers, caregivers, and school mental health counsellors) emphasised the importance of involving caregivers in such programmes. The stakeholders argued that, although involvement might be difficult, caregivers should be involved or informed of the programme to help with the reinforcement of the content. Furthermore, caregivers felt that being involved would benefit them as such programmes would also teach them skills, provide them with support, and promote the caregiver-child relationship (Coetzee et al., 2021). Consequently, the stakeholders involved in the development of CYP recognised the importance of involving caregivers in CAMH interventions.

For CAMH interventions in South Africa to benefit from caregiver involvement, and vice versa, caregivers need to actively engage with such programmes. However, the available South African studies generally show low rates of recruitment and retention (Bhana et al., 2014; Cluver et al., 2016; Cluver et al., 2018; Eloff et al., 2014). Studies investigating the poor involvement of South African caregivers in CAMH interventions have shown that caregivers perceive multiple barriers and facilitators in engaging with such interventions. For example, Shenderovich et al. (2018) and Wessels et al. (2016) report that caregivers experience barriers such transport, hunger, irregular working hours, and other home responsibilities, often caused by low socio-economic status. For others, personal health issues and alcohol abuse were frequent barriers to attending programme sessions (Shenderovich et al., 2018; Wessels et al., 2016). Furthermore, group dynamics such as sharing personal information and attrition affected parents' willingness to attend the programme (Wessels et al., 2016). However, caregivers explained that close proximity of the meeting place and early morning sessions, family buy-in, and good programme content and facilitation were important facilitators to attending sessions (Wessels et al., 2016). Awareness of and addressing common barriers and enhancing facilitators may help caregivers engage with CAMH interventions, thereby enhancing the programme's efficacy and ensuring that caregivers benefit from its content.

Conclusion

This chapter provided an overview of the mental health crisis among both adults and children worldwide and in South Africa. I highlighted the need for prevention and early intervention and the role caregivers may have in engaging with mental health services on behalf of their children. I provided a summary of the global literature on the common barriers and facilitators caregivers encounter in their role as agents in the help-seeking process. Finally, I discussed the importance of involving caregivers in CAMH interventions and supporting caregivers to actively engage with such interventions. This chapter provides a background for present study and forms part of the framework that informs the rest of the research process.

Chapter 3

Theoretical Framework

Introduction

In this chapter, I present the theoretical framework within which my research study is positioned. I start the chapter with a discussion of research paradigms, and in particular, the basic tenets of constructivism. I then explore the ontological, epistemological, and methodological stances of constructivism and apply these approaches to my own research. Following this, I describe my approach to the search of literature and theory as part of the research process and conclude with an overview and critique of the applicable theories used for the interpretation of the data in this study.

Research Paradigm and Constructivism

All researchers, whether they are aware of it or not, possess their own unique belief system that determines how they experience, interpret, engage, and relate to their environment (Guba & Lincoln, 1994). These beliefs influence the researcher's decisions on how and what should be studied and how the findings should be understood (Bryman, 2012). These world views, or research paradigms, are sets of philosophical beliefs and assumptions on the inherent features of reality, the position of an individual in this reality, and how an individual interacts with this reality (Guba & Lincoln, 1994). The type of research question(s) asked usually determines the most appropriate research paradigm, ultimately informing every aspect of the research process, including the research design, and how data are collected, processed, analysed, and interpreted (Collins & Stockton, 2018; Leavy, 2014). Therefore, researchers need to be aware of the research paradigm with which they align themselves to determine how these research steps should be followed.

In selecting the applicable research steps to ultimately answer the research questions, one should consider three important questions regarding ontology, epistemology, and methodology (Guba & Lincoln, 1994). Each of the well-known paradigms, including positivism, postpositivism, critical theory, and constructivism all have different answers to the ontological, epistemological and methodological questions (Guba & Lincoln, 1994). Table 1 offers a basic description of four major research paradigms with respect to their position on these questions.

Table 1

Overview of Four Major Research Paradigms and their Ontological, Epistemological, and Methodological Positions

Item	Positivism	Postpositivism	Critical Theory	Constructivism
Ontology	Naive realism: There is a single objective reality that can be known	Critical realism: Reality exists, but cannot be fully understood	Historical realism: Reality shaped by societal factors and crystalised over time	Relativism: Reality is constructed and cannot truly be known
Epistemology	Dualist / Objectivist: The researcher is separate from the research	Modified dualist/ Objectivist: Truth can be studied with efforts to reduce researcher contamination	Transactional / Subjectivist: Researchers and participants' reality is shaped by what they know (value mediated)	Transactional / Subjectivist: Researchers and participants' reality is shaped by what they know (created findings)
Methodology	Experimental / Manipulative; verification of hypotheses; mostly quantitative methods	Modified experimental; falsification of hypotheses; may contain qualitative methods	Dialogic / Dialectical	Hermeneutical / Dialectical

Note. Adapted from *Competing paradigms in qualitative research* (p. 112*)* by E. G. Guba and Y. S. Lincoln, 1994. In "*Handbook of qualitative research*," by N. K. Denzin and Y. S. Lincoln (Eds). Thousand Oaks, CA: Sage.

The aim of this research study is to investigate caregivers' conceptualisations and understanding of their involvement in their children's MH and MHS. Since one's conceptualisation and understanding of a topic is highly individualised and context specific, constructivism may be more suited in approaching the research question. Constructivism starts with the assumption that social reality is relative to individuals and their contexts. If one or both the individual and the context were to change, it would have consequences relative to reality (Lincoln & Guba, 2013). Constructivism proposes a systematic way of answering the three fundamental questions of a research paradigm (Lincoln & Guba, 2013). Firstly, constructivism takes on the approach of relativism regarding the ontological question “What is reality?”, meaning that reality is subjective and relative to each individual. Secondly, constructivism approaches epistemological question “How do you know something?” with transactions and subjectivism, meaning that we co-create a subjective reality by interacting with one another. Lastly, constructivism approaches methodology, “How do you go about finding it out?”, with hermeneutic/dialecticism, meaning that we find the answers to our questions by exploring meaning-making through conversation. Below I explore each of these elements of the research paradigm in further detail and discuss my understanding of this in my research.

Ontology (Relativism)

Ontology is the study of the nature of social entities, reality, and what we can know about it (Bryman, 2012; Guba & Lincoln, 1994; Leavy, 2014). Ontology asks us to consider whether all individuals share an external, objective and independent reality or whether reality is internal, subjective, and created by the perceptions of the individual (Bryman, 2012). Or simply put, it asks us what truth and reality is (Antwi & Kasim, 2015).

Constructivism considers reality to be relative (Guba & Lincoln, 1994). This means that reality is understood as multiple, intangible mental constructions that only exist in the mind that considers them (Lincoln & Guba, 2013). This means that many realities can exist simultaneously and be considered by different individuals (Leavy, 2014). Consequently, there is no ultimate truth or understanding of the world, as each individual independently develops their own understanding and interpretation of reality formed by their subjective experiences.

Adopting a constructivist ontology of relativism in my research, I assume that every social entity involved in this project, i.e., the participants, stakeholders, myself as the researcher and my supervisor, all have our own subjective reality that only exists for each of us. Despite the similarities or differences that might exist in these constructs, there is no universal truth, objective understanding, or perception of reality. This means that there is no ultimate objective answer for how caregivers are involved in the mental health of their children, but one might attempt to understand the different perceptions the involved actors may have to better understand the main research question.

Epistemology (Transactional Subjectivism)

Epistemology is the study how we come to know something (Guba & Lincoln, 1994), or how we can claim to know something (Willig, 2008). It is related to the process of gaining knowledge and the relationship between the individual (the researcher) and the knowable (the world) (Leavy, 2014). Epistemology asks us whether knowledge is something that can be acquired or is something we have to experience (Kivunja & Kuyini, 2017).

In constructivism, reality is something relative, differing from one individual to the next. Therefore the relationship between the individual and the knowable is transactional and subjectivist (Guba & Lincoln, 1994; Lincoln & Guba, 2013). This means that we know things by interacting with one another, co-creating another reality from which to learn. This transaction is highly personal and context-specific, mediated by the knower’s experiences, knowledge, values, interpretations, and beliefs (Lincoln & Guba, 2013). Knowledge is not obtained but rather created and only exists in the milieu in which the transaction takes place (Lincoln & Guba, 2013).

Adopting a constructivist world view means that I assume that I gain knowledge by interacting with my research participants. During this interaction, my research participants and I actively participate in co-creating a reality and understanding of the world. This co-created reality is a unique combination of our own subjective worlds, which are greatly influenced by our own histories, biases, beliefs, and contexts, and the context within which the conversation takes places. Through the process of co-creation during each unique interaction with my research participants, I can gain insight into multiple constructed realities. However, the co-creation of reality only occurs in the specific time and space in which the participant and I are interacting. This means that this co-created reality only exists for that moment. Any conclusions or understandings of reality are therefore only applicable to that specific moment and cannot be generalised or understood as the truth for others outside of the research sample.

Methodology (Hermeneutic/Dialecticism)

Methodology is the plan for how research will be conducted, including both the methods and the theory (Leavy, 2014). Methodology asks us how the knower can go about finding out the knowable (Guba & Lincoln, 1994). The methodological aspects of a research project must agree with the elements of ontology and epistemology.

Considering that constructivism accepts the assumptions of relativism and hermeneutic/dialecticism, it follows that the appropriate methodology would be to explore meaning-making and sense-making of the knowers who are involved (Lincoln & Guba, 2013). To do so, two processes are required, namely hermeneutics and dialecticism. Hermeneutics involves the process of continually moving from the interpretation of smaller to larger units of meaning in order to better understand both (Leavy, 2014). This allows delving into the constructions held by the knowers by disclosing and testing constructions for meaning. These meanings are found by having the researcher and participants work together to explore the issues that are important to them (Lincoln & Guba, 2013). Dialecticism, i.e. conversation, is the most suitable way in which to identify and confront constructions in an encounter situation (Lincoln & Guba, 2013). The hermeneutic/dialectical methodology thus entails the formation of a hermeneutic cycle of the constructs held by both the researcher and participant with respect to the concepts associated with the research question. The hermeneutic cycle, in turn, then reassesses and negotiates these constructs until a consensual construction emerges (Lincoln & Guba, 2013).

Adopting a constructivist approach to methodology, I attempt to gain knowledge through qualitative, semi-structured interviews. During the conversations with my participants, we spoke about the topic of their (caregivers') perception of their role in their children's MH and MHS. During this conversation we can negotiate and test our understandings against one another to co-create a reality from which we can learn. However, a semi-structured interview, which includes a series of open-ended questions, acts as a framework for this discussion, and ultimately the co-creation of reality. Although this framework might limit our co-created reality to certain components, it does leave space for both the research participants and I to incorporate other knowledge. This allows me, as the researcher, to guide the conversation towards answering the research question, but to also incorporate other relevant information beyond my own understanding of the research question and objectives.

Approaching the Literature and Theory

Considering that little is known on the topic of caregiver involvement in children's MH and MHS in the context of South Africa, the current study is considered exploratory in nature. The aim of exploratory research is to determine the scope of the topic to ultimately guide further research and theory development, usually by means of qualitative research (Bless et al., 2013). The aims of exploratory research might therefore have some implications for how literature and theory is approached.

According to Collins and Stockton (2018), exploratory research could benefit from being more *unhinged* from strong theoretical frameworks. Indeed, an over-reliance on theory could create a myopic view, thereby preventing the salience of data to show and potentially creating confirmation bias (Collins & Stockton, 2018). However, a balanced and centred use of theoretical frameworks in research aids in identifying certain assumptions and connections, which then allows a researcher to search for information that either confirms or challenges the assumptions and predictions (Collins & Stockton, 2018; Maxwell, 2013).

Considering the relationship between exploratory research and the theoretical framework, I approached the use of theories inductively by identifying multiple theories that might be useful in the sense-making of the findings of this study. Doing so helped me organise the data in meaningful ways and to shine a light on themes that might have been overlooked if I rigidly applied a specific theory to the analysis of the findings (Maxwell, 2013). However, I made use of literature on the research topic, research paradigms, and concepts such as mental health literacy and help-seeking to create a centred and balanced theoretical framework to help inform me in the development of my research question, research design, methods, and data analysis (Collins & Stockton, 2018).

I approached the literature review in a similar manner. There is ongoing debate among qualitative researchers about when the literature should be read. Some researchers discourage conducting a literature review before data collection and data analysis, as it is believed that by doing so, a researcher can act deductively, removing themselves from the research project to produce an uncontaminated product (Ramalho et al., 2015). However, the latter idea is incongruent with the epistemological assumptions of constructivism (Lincoln & Guba, 2013). The influence of the researcher is neither avoidable nor undesirable, but should be included in the research process (Ramalho et al., 2015). I conducted a brief literature review of scholarly articles and a wider range of material before developing my research questions and design. Doing so helped me identify the gaps in research, developing the rationale for the research and a specific research question. Doing a brief literature review allowed me to be more open and receptive to new and unexpected themes and constructs that I may have disregarded if I had a more in-depth understanding of the literature.

Theoretical Orientation

As explained above, identifying applicable theories following data analysis allowed me to organise and interpret the data in a meaningful way, while not potentially discarding findings that do not fit into an a priori theoretical framework. Considering the findings of this study, I have identified two theories that have been helpful in my interpretation of the data. These are (1) the theoretical model by Hassett et al. (2018) on parent involvement in mental health help-seeking and (2) the model of parent appraisal, thinking about seeking help, and service receipt by Godoy et al. (2014).

Help-Seeking

Behaviour change theories (BCTs), for example, the health belief model (Rosenstock, 2005) and the theory of planned behaviour (Ajzen, 1991) have been applied to the help-seeking process for mental health problems, (see Graham et al. 2017; Langley et al. 2018; Tomczyk et al. 2020). Although BCTs have been used to explain how individuals engage with the help-seeking process for mental health support, they have not been widely accepted (Gulliver et al., 2012). Furthermore, to my knowledge, BCTs have not been applied to caregivers seeking help for their children's mental health problem. The use of BCTs in mental health help-seeking have therefore not yet incorporated the perspective of seeking help on behalf of someone else, and it would be presumptive to assume the process would be the same. However, a broad understanding of help-seeking processes could provide a general framework that could be applied to the current study.

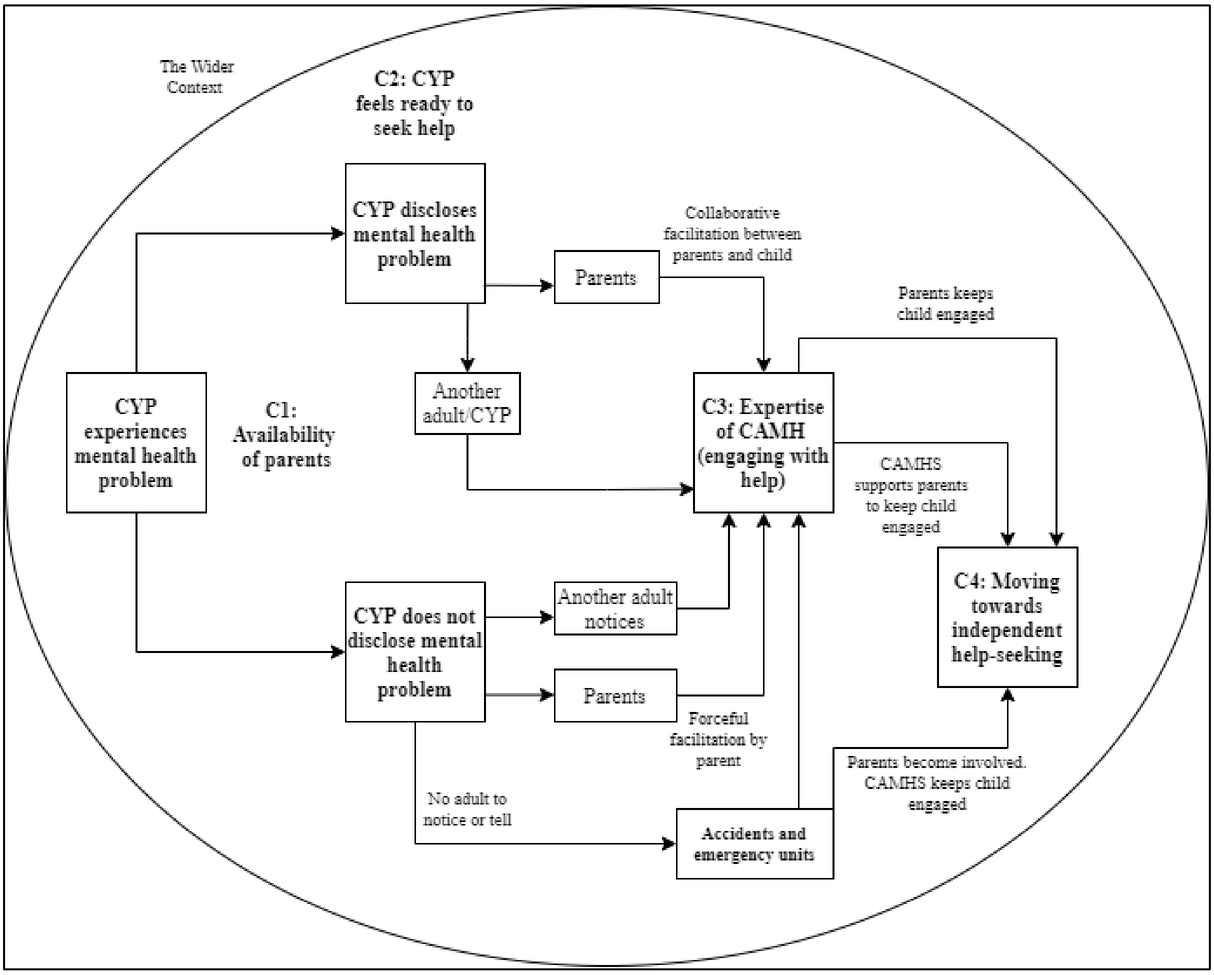
According to Gulliver et al. (2012), many BCTs have three common elements in explaining help-seeking behaviour, including (1) *attitudes*, or an individual's beliefs about the behaviour and willingness to engage with it (2) help-seeking *intention*, and (3) the actual *behaviour*. Keeping these components in mind helped me make sense of the process of help-seeking and how the research participants' perceptions, beliefs, and attitudes might influence their intention to seek help and the actual help-seeking. Additionally, the theory set forth by Hassett et al. (2018) is likely to help me interpret findings specifically relevant to the involvement of caregivers in mental health help-seeking on behalf of their children.

Hassett et al. (2018)

Considering the potential role caregivers play in their children's help-seeking for mental health problems, Hassett et al. (2018) aimed to develop a grounded theory of the influence that caregivers have on their children's help-seeking. The researchers conducted 18 semi-structured interviews with adolescents (aged 13–18) and their parents or caregivers who have engaged with CAMHS, as well as CAMH clinicians. The resulting model, consisting of five core categories, describes the journey of help-seeking both the child and caregiver navigate, from the initial perception of the mental health problem until the engagement with mental health professionals (Figure 1).

Figure 1

Preliminary Model Representing Caregiver Influences on Children and Young People's Mental Health Help-Seeking Journey



Note. Adapted from "Parental Involvement: A grounded theory of the role of parents in adolescent help seeking for mental health problems." by A. Hassett, C. Green, and T. Zundel, 2018, *SAGE Open, 8(4)*, p. 6 (https://doi.org/10.1177/2158244018807786).

Category One: Availability of Caregiver. According to the model, the availability of caregivers, both physically and emotionally, influences whether CYP would feel comfortable disclosing their mental health problem to their caregivers. Furthermore, caregiver availability also influences how able caregivers are to support their child and how they and their child will collaborate in the help-seeking process. The latter is often influenced by the caregivers' beliefs about help-seeking.

Category Two: CYP Feels Ready to Seek Help. Feeling ready to seek help is a key point in the help-seeking process for CYP. Feeling ready helps them feel in control to some extent, use support from caregivers, and begin to engage with CAMHS. CYP's feelings of being ready to respond to their mental health problem seem to be influenced by how they perceive the problem, their beliefs about seeking help, and their stage of development.

Category Three: The Expertise of CAMHS. Clinicians working in the CAMHS are able to involve parents in their child's mental healthcare. These clinicians are able to support caregivers in developing their availability and involvement, and to help caregivers engage their child with CAMHS and to engage CYP directly.

Category Four: **Moving Towards Independent Help-Seeking**. Engaging with CAMHS, CYP begin to develop a better understanding of their mental health and how to seek help when necessary. This seems to help CYP become more independent in their own help and support-seeking and less reliant on their caregivers.

Category Five: The Wider Context. Caregivers, CYP, and clinicians perceive that the help-seeking process functions within a wider context. The wider context, including the family context, CAMHS context, and societal awareness of help-seeking, influences caregiver and CYP help-seeking.

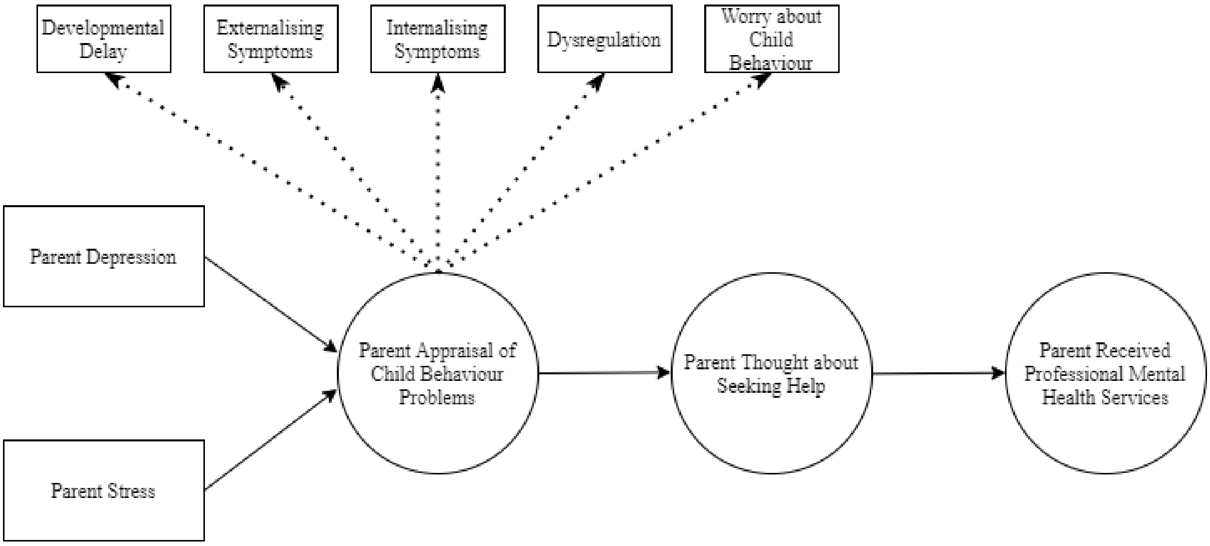
The theory postulated by Hassett et al. (2018) emphasises the role of the caregiver in CYP's mental health help-seeking. CYP may have trouble accessing mental health services on their own without the assistance of a caregiver or another adult. This theory provides a framework for how caregivers and their child can (or then cannot) cooperate and collaborate in the help-seeking process. Applying this process to my own study, it provides a lens through which I can interpret and organise my data to provide insight into how the research participants are involved in their child's mental health help-seeking. It is, however, important to recognise the theory's limitations. Firstly, although the authors made use of triangulation to ensure validity, the sample of participants were recruited from a similar context in South London, England. It is likely that the cultural and contextual factors associated with the theory development may not be applicable to the South African context, and more specifically to the current study's sample. Secondly, the included sample in Hassett et al. (2018) were caregivers and their children who have successfully engaged with CAMHS. Consequently, the perspectives and experiences of individuals who have not successfully engaged with CAMHS are not included and the factors contributing to this occurrence are not accounted for. It is therefore important to consider the contextual and cultural context of the current study as well as the different experiences of caregivers who have, or have not, engaged with CAMHS.

Godoy et al. (2014)

Caregivers are among the first to recognise mental health problems in their children and are therefore considered influential agents in the help-seeking process. Understanding caregivers' appraisal of their children's mental health problems are therefore crucial in reducing unmet mental health needs among children. Godoy et al. (2014) aimed to produce a model of the influences on caregivers' (1) appraisal of child behaviour, (2) thoughts about help-seeking, and (3) receipt of professional mental health services. The researchers interviewed 189 caregivers of children aged 11–60 months. Using structural equation modelling, the authors examined caregivers' appraisal of their children's behaviour (perception of a behaviour as problematic), thoughts about help-seeking, and the receipt of mental healthcare. The resulting model can be seen in Figure 2**.**

Figure 2

Final Model of Caregiver Appraisal, Thinking About Seeking Help, and Service Receipt



Adapted from Godoy, N.D. Mian, A.S. Eisenhower, and A.S. Carter, 2014, *Administration and Policy in Mental Health and Mental Health Services Research*, *41(4)*, p. 476 (https://doi.org/10.1007/s10488-013-0484-6).

The results indicated that, firstly, caregivers' appraisal of their children's behaviour was significantly and independently influenced by developmental delays, worry about the behaviour of the child, as well as the child's specific internalising, externalising, and dysregulation symptoms profile. Secondly, caregiver stress and depression were also significant positive contributors towards a caregivers' latent appraisal construct (perceptions of the child's behaviour beyond the frequency of the behaviour). Lastly, caregiver appraisals were significantly associated with further thoughts on seeking help for their children's mental health problem, which was in turn significantly associated with service receipt.

In the current study, participants' ability to recognise and assess their children's mental health problems was a central theme in their involvement in their children's MH and MHS. This theory by Godoy et al. (2014) might help to shed some light on how caregivers' appraisal of children's mental health problems may influence the help-seeking process. It is, however, important to consider the limitation of this theory and its applicability to the current study. Firstly, the sample in Godoy et al. (2014) included caregivers of children in their early developmental phases (infancy to early childhood), while the current study recruited caregivers of children in their early adolescence. It is a possibility that the key developmental differences between these childhood phases may have different influences on caregiver appraisal of their child's mental health symptoms. Secondly, the study does not account for motivational factors (for example, beliefs about the costs of services) or explanatory models (for example, parents beliefs about the causes of mental health problems) and might therefore limit this theory's explanatory power of the findings of this study. It is therefore important for this study to consider whether factors specific to adolescence, motivation, and explanation of the causes of mental health might influence caregiver appraisal and their thoughts on help-seeking, in if so, which factors those are.

Conclusion

In this chapter, I highlighted the importance of research paradigm and provided an overview of constructivism and how its tenants regarding ontology, epistemology, and methodology applies to the current study. I also motivated and described my inductive approach to the literature review and theory. Lastly, I gave an overview of the help-seeking theories that were helpful in the interpretation of the data, specifically the work by Hassett et al. (2018) and Godoy et al. (2014).

Chapter 4

Methods

This chapter offers a detailed description of each step of the research process for the sake of transparency. I begin by motivating my research design and data collection methods. I then describe and motivate the inclusion criteria and how I went about recruiting the participants for this study. Following this section, I describe the data collection procedure and the measures used during interviewing. I dedicate a section to the impact of the COVID-19 pandemic on the research process and motivate my decision to incorporate secondary data in the data analysis process. I then give a detailed description of the analysis process of both the original data and secondary data. I conclude the chapter with insight into the ethical considerations and trustworthiness, as well as my reflections on this research study.

Research Design

In this study, I have used an exploratory, qualitative research design with semi-structured interviews. According to Swedberg (2020), an exploratory study can be conducted for two different purposes. The first is to increase the knowledge about a little-known research topic. The second is to produce a novel hypothesis about a topic that is already known. Considering that the topic of caregiver involvement in children's MH and MHS is poorly understood in the South African context, the purpose of this study falls into the former category, i.e., increasing knowledge about the topic. Consequently, this exploratory study aims to determine the breadth and depth of the topic of investigation in order to develop more specific questions to guide subsequent research (Bless et al., 2013).

A qualitative research design is most appropriate for exploring this topic. Qualitative research is well suited to explore, describe, or explain social phenomena (Leavy, 2014). It attempts to understand the social reality from the perspective of the participant and to understand this phenomenon in its natural context (Bless, Higson-Smith, & Sithole, 2013). A qualitative research design is therefore well suited to explore how caregivers perceive their involvement in their children's MH and MHS.

In this study, I used semi-structured interviews to collect data. As described in Chapter 3, this study is located in the constructivist research paradigm, for which interviews, specifically semi-structured interviews, are a suitable methodology. Semi-structured interviews typically entail a series of open-ended questions and probes that aim to elicit the interviewee's point of view on a framework of themes (Bryman, 2012). However, unlike structured interviews, semi-structured interviews offer the flexibility to incorporate new ideas, questions, and probes in response to the information provided by the interviewee (Bryman, 2012). This form of interviewing allows both the interviewer and interviewee to become participants in the co-creation of knowledge through dialogue, but places the interviewer in a position to steer the conversations to matters relevant to the research topic (Leavy, 2014). Furthermore, it is compatible with many types of data analysis techniques and there is relative ease in constructing the interview guide (Willig, 2008). Although semi-structured interviews were suitable for collecting data in the present study, there are disadvantages. Semi-structured interviews are costly in terms of time and money (Bless et al., 2013). Interviewing participants requires a researcher to spend a certain amount of time with each participant separately and may require travelling to reach these participants. The transcription, translation, and analysis of these interviews are also time and work intensive compared to other forms of data collection. Furthermore, the quality of data to be collected by means of semi-structured interviews is also highly dependent on the skills of the interviewer (Bryman, 2012).

Research Setting

This qualitative study took place at a selected government funded primary school in Stellenbosch in the Western Cape province of South Africa. In total, the school has 23 educators and 748 learners (Grade R to Grade 7), which is an average educator-learner ratio of approximately 1:33. Classes are mainly taught in Afrikaans. The school is supported by several non-governmental organisations that provide, among other things, academic and psycho-social support. The school also forms part of South Africa's National School Nutrition Programme (Devereux et al., 2018). Eligibility for this programme requires that the majority of learners come from families with low socio-economic status. At this specific school, approximately 690 learners (90%) make use of this programme. This specific school was selected due to its close proximity to Stellenbosch University, which limits travel costs and helps to build positive stakeholder relationships. Furthermore, the selected school is supported by an NGO that provides free therapeutic counselling and psycho-social support to educators, caregivers, and learners. The presence of such an NGO on the school premises not only provides support with risk mitigation but provides caregivers with a frame of reference for available mental health services for their children.

Participants

I made use of purposive sampling to identify and recruit participants. Purposive sampling is a non-probability form of sampling that strategically includes participants that are relevant to the research question (Bryman, 2012). Purposive sampling thus allows the researcher to select individuals they deem most suitable for a research study, increasing the likelihood of gathering in-depth, rich, and meaningful data for the purpose of answering the research question (Leavy, 2014). Furthermore, specifying the sample to be included in a research study decreases the number of participants to be recruited (Malterud et al., 2016). Consequently, I purposively sampled participants who were:

1. the caregiver of at least one child (Grades 5–7 and between the ages of 11 and 14) attending the selected primary school;
2. 18 years and older; and

3. fluent in either Afrikaans or English.

I chose these specific inclusion criteria for several reasons. Firstly, to answer the research question, it was necessary to include participants who are indeed the primary caregivers of children. The term caregiver is understood as any person who takes the bulk of the responsibility for the daily care and rearing of a child. This may include but is not limited to biological parents, family members, foster parents, or legal guardians. Including caregivers in this research study allowed me to explore their perceptions of their involvement in their children's MH and MHS. I further restricted the inclusion criteria by only including caregivers of children between the ages of 11 and 14. As reported in Chapter 2, the onset of common mental health problems, including depression and anxiety, often occurs around the ages of 11 to 14 (Kessler et al., 2005, 2007). By limiting the inclusion criteria to only caregivers of children between these ages, it was possible to narrow the focus to caregivers of children who fall into a critical period of mental health problem development. The findings of this research study can therefore provide insight into this critical period in the development of mental health problems, providing relevant and meaningful information to inform future prevention programmes and research. Secondly, I limited my inclusion criteria to only include caregivers older than 18 years of age. Although child-headed households are a reality in South Africa, it only makes up a small minority, and is thus not representative of typical South African household with children (62% extended households, 25% nuclear households, 10% lone parent households, and 2% composite households) (Hall & Mokomane, 2018). Furthermore, caregivers under the age of 18 are legally considered to be children. Including underaged participants in this study not only has implications for research ethics but may also make the findings of this study ambiguous, as underaged caregivers fall into both the category of child and caregiver, making it difficult to distinguish between the perceptions of a child and a caregiver. Lastly, I only included participants who were fluent in Afrikaans and/or English. As

I am fluent in both Afrikaans and English, I could easily conduct interviews in both languages. Due to financial restrictions, I could not expand the inclusion criteria to other languages, as this would require the employment of interpreters during the interviews and transcribers and/or translators have the data had been collected. However, excluding participants who speak other languages did not prove to be a problem considering that the majority of the community from which I sampled speak Afrikaans as a home language.

Recruitment Strategy

I received permission to recruit participants and conduct this research study from all the necessary stakeholders, including the current principal of the selected primary school (Appendix A), the Western Cape Education Department (WCED) (Appendix B1), and the Stellenbosch University Research Ethics Committee: Social, Behavioural, and Education Research (REC:SBER; Appendix C). The WCED initially granted permission for recruitment at the selected school between 1 August and 18 September 2019. I requested an extension of this period to continue recruitment and data collection in the year 2020. WCED complied and extended the permitted period to 31 March 2020 (Appendix B2).

I received permission from the school principal to approach learners in the relevant grades about the study. I recruited participants by distributing a flyer with information among the learners in Grades 5–7. The information flyer, along with a contact permission form (Appendix D), provided information on the study and participation. I instructed the learners to take these forms to their caregivers. Caregivers who were interested in participating in the study were asked to send the filled-in and signed contact permission form back to school with their child. The learners were then instructed to place the permission form in an orange box that had been placed in the classroom. I then collected the forms from the school on a weekly basis until educators indicated that no new forms were collected (more or less three weeks). I proceeded to contact the interested participants telephonically and arranged an interview date and time at their convenience. Convenient dates and times were generally negotiated around the beginning or end of the school day to ease transportation for participants. Furthermore, if participants were employed, the particular day and time were scheduled to ensure that they did not have to take a leave of absence from work.

I aimed to interview a minimum of 20 participants. The number of participants were informed by the experience of my supervisor and the consideration of the model of informational power as proposed by Malterud et al. (2016). This minimum number of participants were, however, kept under revision throughout the data collection and analysis phase by determining whether data saturation for adequate thematic analysis had been reached (Fusch & Ness, 2015). This means that recruitment and data collection were conducted simultaneously until new interviews yielded little additional information (Leavy, 2014).

Informational flyers were handed out to approximately 250 learners. Of the 250, a total of 29 caregivers (11.6%) showed interest in participating in the present study by sending back the contact permission form to school. However, only 10 participants were interviewed. The remaining 19 interested participants were not interviewed due to a lack of or incorrect contact information, not being able to reach participants following three attempts, difficulty scheduling an appropriate interview date and time (employed caregivers), or participants who chose not to participate upon receiving further information.

Data Collection

I interviewed all the participants once in Afrikaans and/or English, depending on their language of preference. I aimed to complete interviews (consent and measures) in 45 to 60 minutes, with the average interview time (measures only) being 36.5 minutes. All of the interviews were performed in a private room on the school premises. To protect the anonymity of the interviewee and confidentiality of the interview, a sign (written in both

English and Afrikaans) was placed on the door to inform others that an interview was in progress and to not disturb. Participants were given light refreshments, which consisted of a bottle of water and a sandwich. Participants were not informed of the refreshments before the onset of the interview as to not incentivise participation. Before the commencement of the interview schedule, I discussed the consent form (Appendix E) with the participant thoroughly and answered all questions they had regarding the study and participation. The participants were then asked to provide written consent. The participants were provided with a copy of the consent form if they wished to receive one. With informed consent of the participant, I audio-recorded the interview to transcribe the interview verbatim. All participant agreed to be audio-recorded. After each interview, I made detailed notes to reflect on my experience, interpretation, and understanding of the interviewee's responses.

Measures

I administered two measures, including a demographic form (Appendix F) followed by an interview schedule (Appendix G). The semi-structured interview was constructed by (1) identifying the research objectives, (2) deciding what kind of data are needed to explore these concepts, and (3) formulating specific questions that would lead to relevant data collection (Bless et al., 2013). I also considered the number and depth of the questions to limit the interview time to under an hour so that I would not tire the participants but still be able to gather rich and in-depth data. Furthermore, I paid close attention to the language and vocabulary to ensure that the questions were easily understandable, straight-forward, and not leading in any way. I also ensured that the questions follow logically as to promote comfortable conversation. The interview schedule started with an introduction to the research study, including the aims and objectives and what the participant can expect from the interview. I then asked a set of open-ended questions that was designed to illicit spontaneous responses from the participants. The interview schedule also allowed me to ask appropriate follow-up and probing questions.

The demographic form was structured with questions pertaining to common sample characteristics that I thought would help to produce a well-rounded description of the sample group. The demographic form asked participants to report on their age, gender, home/first language, employment status, how many hours a day they spend with their child, their relationship to the child, and during which activity they spend the most time with their child.

To test the measures for time and clarity, I conducted a pilot interview with a participant. My supervisor then reviewed the pilot interview and provided constructive feedback. I then made the appropriate changes to the measures before continuing with data collection. In response to certain open-ended questions, the participant often spoke spontaneously to questions yet to be asked. Consequently, I identified these questions and changed them into probes to be used in the later interviews if needed. The participant also had trouble understanding the questions on the conceptualisation of mental health terminology and I consequently simplified and reworded these questions to enhance understanding. I also rearranged the position of some of the questions in the interview schedule to promote spontaneous conversation. As only minor changes were made to the interview schedule and I was still able to elicit responses to all of the questions, the data collected from this participant was included in the analysis process.

Implications of the COVID-19 Pandemic on Recruitment and Data Collection

Postponement of Research

The ongoing outbreak of Coronavirus Disease 19 (COVID-19) was declared a Public Health Emergency of International Concern in January 2020 and officially classified as a pandemic in March 2020. To curb the spread of the disease, the South African government implemented a national phased lockdown from midnight on the 26th of March 2020, which placed varying restrictions on movement (national and international), sales of certain products (including tabaco and alcohol), social and religious gatherings, evictions, and the opening of non-essential businesses. In response to these restrictions, Stellenbosch University postponed all research activities, including research that requires human contact. Complying with the regulations set forth by the South African government and Stellenbosch University, I did not continue recruitment and data collection during lockdown or after the first relaxation of research restrictions.

Firstly, further recruitment and interviewing was not possible. Having completed my first round of recruitment and interviewing at the time the restrictions were put in place, it would have been necessary to conduct a second round of recruitment to identify any further interested individuals. With the research restrictions in mind, my recruitment strategy, as described before, would not have been executable, nor would a change in recruitment strategy be suitable. The option of recruiting participants via telephone would have required me to collect the private numbers of parents/caregivers from the school. This would, however, have been an unethical breach of their privacy and use of private information for reasons not intended when entrusted with the school. Furthermore, this could possibly cause distrust in the school system and the research project.

Secondly, it was likely that there would have been a stark difference in the data collected pre-COVID-19 lockdown compared to data collected in the midst of the COVID-19 pandemic. As seen in the last two years, the COVID-19 pandemic had a major effect on the mental health of families living in South Africa (Abrahams et al., 2020; Gittings et al., 2021; Posel et al., 2021; Coetzee, et al. under review). To reconcile the differences in data pre- and post-lockdown, I would have had to reassess the entire research study, which would possibly have had serious consequences for answering the research question.

Lastly, at the time the restrictions were put in place, a pragmatic decision had to be made with the information and time available to me. Uncertainty regarding the timing of the return to usual research practices, the opening of schools and their permission to continue research, and the relaxation of government restrictions led me to the decision to suspend my research activities indefinitely.

The COVID-19 pandemic and research postponement brought many challenges for the quality of this research study. Having completed and analysed 10 interviews at the time lockdown was imposed, data saturation had not yet been reached, which had serious implications for the extent to which the I could adequately answer the research question and make insightful conclusions. To improve the depth and richness of my data, I incorporated secondary data originally collected as part of a Wellcome Trust funded study titled *The acceptability and feasibility of a CBT-based psychoeducational intervention to support psychological well-being amongst adolescents in schools in South Africa* (Bradshaw et al., 2020; Coetzee et al., 2021; Coetzee et al., 2021).

Incorporation of Secondary Data

The Wellcome Trust funded study is led by Dr Bronwyne Coetzee and comprises of an international team of researchers, including myself in the role of research assistant. The study received ethics approval from the Stellenbosch University's Research Ethics Committee: Human Research (Humanities) (SU project number: 9183) and the Western Cape Education Department (Reference: 20190213–1562). The study aims to develop a CBT-based psychoeducational intervention to support the mental wellbeing of CYP in schools in South Africa. There are a number of reasons why the data collected in the Wellcome Trust study was suitable and relevant for the use in this current study.

Firstly, there are several similarities in the research design. Both studies used semi-structured qualitative interviews to explore participants' conceptualisation of typical mental health terminology and the coping mechanisms employed by family members to deal with the emotions and mental health issues of their children. Furthermore, both studies asked similar demographic questions. The full interview schedule and demographic measures of the Wellcome Trust study can be found in Appendix H. Consequently, the Wellcome Trust data were suitable for meeting the first three research objectives:

Although not specifically posed as questions in the Wellcome Trust study, my familiarity with the data assured me that participants spoke spontaneously about their experiences with mental health services and their role as caregivers in the mental health of their children. Thus, additional data were available to meet the remaining research objectives.

Secondly, having been personally involved in the collection, transcription, translation, analysis, and write-up of the Wellcome Trust data, I was familiar with the research settings; the cultural, and individual nuances and contexts of the participants; the analysis process; and the content of data. This enabled me to expertly merge the two datasets and analyse it as a whole.

Thirdly, both studies had similar inclusion criteria, with the sample consisting of participants who are primary parents/caregivers of children (Grades 5–7) attending government funded primary schools in the Western Cape with similar socio-economic statuses. The homogeneity of the sample groups allowed for successful merging of the data. Furthermore, the addition of 21 interviews to the initial 10 interviews (a total of 31 participants), provided enough information to reach data saturation, allowing the analysis of rich and in-depth data and meaningful conclusions.

There are, however, some considerations to keep in mind when analysing, reporting, and discussing the findings. Although all three schools at which data collection occurred are in close proximity, two schools could be considered urban while the third (where I collected primary data) is rural. It is therefore important to consider the possible differences in the availability of resources, support networks, social isolation, education, and poverty, which may ultimately influence how the results may be interpreted.

Data Analysis

The data from both studies were analysed as a single corpus (all interviews together) using the hybrid thematic analysis approach explained below (Fereday & Muir-Cochrane, 2006; Swain, 2018). I thematically analysed the data with the use of ATLAS.ti software (version 8). During thematic analysis I followed the guidelines set out by Braun and Clarke (Braun & Clarke, 2006; Liamputtong, 2019). I also made use of content analysis (Bryman, 2012) to determine how many participants were able to articulate their understanding of the mental health terminology used during the interview process.

Reflexive Thematic Analysis and Procedure

Thematic analysis (TA) is an umbrella term for a qualitative analytic approach that aims to identify themes in a qualitative dataset (Liamputtong, 2019). The three schools of TA are ‘coding reliability’, ‘reflexive TA’, and ‘codebook TA’, each with a distinct underlying philosophy and approach to the dataset. In reflexive TA, themes represent a collection of smaller implicit and/or explicit units (codes) that share meaning, organised around a central concept. Themes are the result or output of analytical work that explores and develops an understanding of the underlying collection of meanings or codes, which in turn is the outcome of coding. Coding, the identification of meaningful quotes, is an iterative process which expresses the researcher’s evolving conceptualisation of the data. The point of reflexive TA is not to ‘accurately’ summarise the data or to minimise the researcher’s subjectivity, as both are impossible, but to produce a coherent and subjective interpretation of the data (Braun & Clarke, 2006; Liamputtong, 2019).

Following data collection, I transcribed each audio-recording verbatim. Where pauses, intonations, volume, emphasis, etc. provided valuable non-verbal information, I indicated these with selected symbols and formatting. Following transcription, I proceeded with a hybrid reflexive TA approach. An overview of the phases of reflexive TA by Braun and Clarke (2006) can be seen in Table 2.

Table 2

Phases of Reflexive Thematic Analysis

Phase	Description
1. Familiarisation with the data	Actively reading the transcripts to search for meanings and patterns and taking notes.
2. Generating initial codes	Organise the data by providing each interesting and relevant segment with an initial descriptive code.
3. Searching for themes	Collating codes that seem to fit together into an overarching theme that say something about the data.
4. Reviewing themes	Refining themes on the level of coded segments as well as the entire dataset.
5. Refining themes	Define and further refine themes to identify the essence of the theme, generating a clear definition and name for each theme.
6. Reporting on the findings	The final analysis and write-up of the report by telling the complicated story of the data with sufficient evidence.

Note. Adapted from "Using thematic analysis in psychology" by V. Braun and V. Clarke, 2006. Qualitative Research in Psychology, pg 35.

Firstly, I *familiarised* myself with the data to shift my focus from data generation to data interpretation. I did this by revisiting audio recordings, transcripts, and field notes of the interviews. I also made notes of what I found interesting and what I regarded as possible connections. Secondly, I *generated codes* using a hybrid approach (inductively and deductively) with the help of ATLAS.ti version 8 (Fereday & Muir-Cochrane, 2006; Swain, 2018). The deductive approach entailed coding the responses of participants according to their understanding of the specific mental health terminology and coping mechanisms. For instance, a participant’s response to “What does the word psychological health problem mean to you?" would be coded with "psychological mental health_" followed by a descriptive initial code that would capture the response of the participant. The inductive process entailed coding the responses of participants beyond the interview schedule that I deemed interesting and nuanced, thereby capturing the full range of participants responses and other salient issues. As pointed out by Braun et al. (2019), these initial codes are often more explicit and semantic, which with experience and iterations become more implicit and conceptual. To assist this process, I discussed my initial codes with my supervisor to gain some insight and perspective and then reviewed my codes accordingly. Thirdly, I *constructed themes* by clustering related codes together to create initial themes and subthemes that encapsulate the underlying patterns of codes. Although ATLAS.ti version 8 provided great functionality in theme and subtheme development and the organisation of data, it was also useful to also visualise the themes and subthemes on a white board. Doing so helped me to easily rearrange themes and subthemes and understand how each fit into the whole dataset. Then lastly, I *revised and refined* the themes and subthemes by checking whether codes related to their selected themes and whether the identified themes and subthemes related to each other. I did so by rereading quotations, revisiting contexts, creating thematic maps, and discussing the potential themes with my supervisor. Insights gained from this process informed the necessary changes and rearrangements of themes and subthemes. This last step was repeated until the final themes and subthemes were identified and fully expressed my interpretation of the data. The analysis of the data adhered to the 15-point checklist for good reflexive TA set out by Braun and Clarke (2006).

Content Analysis and Procedure

Content analysis aims to quantify the content of documents according to predetermined categories (Bryman, 2012). In this study I wanted to determine how many participants were able to articulate, before probing and follow-up questions, their understanding of each of the mental health terms asked during the interview process. While this calculation was not an expressed objective of this study, it is useful in understanding to what extent parents are knowledgeable and familiar with every day mental health terminology such as mental health, mental health problems, emotional health, emotional problems, psychological health, and psychological problems. To do so, I carefully went through each transcript to determine whether the participants were asked the mental health terminology (denoting yes/no), and whether they were able to articulate and understanding of said mental health term (denoting yes/no). To determine the percentage of answers provided for each mental health term (Table 5), I calculated the percentage as follows:

$$\frac{number\ of\ times\ answered}{number\ of\ times\ asked} \times 100$$

To determine how many participants were able to articulate an understanding for all of the mental health terms asked during the interview (Chapter 5), I conducted the following steps for each participant:

1. I counted the number of times a mental health term was asked during the interview.
2. I counted the number of times the participant provided an understanding of the mental health terms asked during the interview.
3. I calculated the total number of participants of steps (1) and (2).

Finally, I calculated the percentage of participants who were able to articulate an understanding of all the mental health terminology they were asked about during the interview with the following equation:

$$\frac{(N\ participants) - (n\ participants\ who\ provided\ an\ answer)}{(N\ participants)} \times 100$$

Ethical Considerations

I obtained ethics approval from from the Western Cape Education Department to conduct this study (see Appendix B) as well as the REC: Social, Behavioural and Education Research (SBER) (see Appendix C). To ensure that this study was executed in an acceptable and ethical manner, I was guided by and adhered to the principles of respect for persons, beneficence, and justice, as proposed in the Belmont Report (1978).

Respect for Persons

I ensured that all participants gave written informed consent before the start of the interview. I also made sure to sign the consent forms of my participants. The consent process was without deception about the purpose or procedure of this research study. Participants were made aware that their participation was voluntary, which gave them the right to withdraw their participation at any point during the research process without any consequence. They were, however, informed that withdrawal following the analysis of the data would not be possible due to the irreversible integration of data.

It is crucial to protect the anonymity of participants so that they feel safe and protected during the research process. This makes them feel comfortable to share their full experiences. To protect the identity of the participants, codes (for example, SCS001, SCS002, SCS003) were used as reference to participants, as well as the organisation and storage of associated data. All the ‘soft’ data (audio recordings, transcripts, notes, analyses) of each participant was stored on a MS OneDrive. These files and documents were encrypted and protected by a password only I knew. Furthermore, a back-up of this data was also stored on OneDrive, to which only Dr Coetzee and I had access to. No data were shared via or stored on external devices. All hard data (consent forms, demographic measures, contact permission forms) of the participants were filed and stored in a locked cabinet in the office of Dr Coetzee.

Beneficence

This study was classified as medium risk for a few reasons (Horn et al., 2015). Firstly, the research topic is considered controversial and might invite the participants to share their personal opinions, personal information, and experiences. Secondly, due to their low socio-economic status, the sample group was deemed vulnerable. The study, therefore, could potentially cause some harm or discomfort. Several steps were taken to ensure the psychological safety of the participants. Firstly, I ensured that all participants were aware of the possible risks and benefits associated with their participation in this study. The relevant information was shared in the information flyer and during the consent process. Secondly, I tried to mitigate any possible negative emotions that might arise during the interview. If a participant were to become visibly distressed (i.e. crying or silent) during the process of the interview, I would ask the participant whether they wanted to continue with the interview, reminding them that they have the right to withdraw from the study if they wished to do so. If they wished to proceed, I would give them a moment of silence before continuing with the interview schedule. Furthermore, if a participant seemed to look uncomfortable answering a specific question (i.e. fidgeting or silent), I reminded them that they do not have to answer the question if they did not want to and that we could proceed with further questions without any consequences. At the end of each interview, I asked participants how they experienced the interview process to provide them with an opportunity to debrief and/or provide constructive feedback. Most of the participants expressed that they felt a sense of relief to be able to talk about these topics and valued being heard. Although these efforts proved to be sufficient in dealing with any discomfort during the interview process, it was also important to put in place a protocol to deal with distress beyond the scope of my training. The chief executive officer of the NGO located at the schools agreed to assist with providing distressed participants with psychosocial support if they wished to do so (Appendix I). When deemed necessary, I would refer distressed participants, whether they chose to withdraw or not, to the NGO's school office manager based at the selected primary school. The office manager would then organise one free counselling session for the distressed participant to receive appropriate support. No such referrals were necessary during the research process. The possible benefits of the research study far outweighed the risks, despite the vulnerability of the group. As the findings of this study can help the development of future mental health interventions for children in these contexts, the community from which the sample was drawn stand to indirectly benefit.

Justice

Due to the low socio-economic status and vulnerability of the participant sample, it is also important to mitigate any power imbalances that may exist. I attempted to empower my participants by engaging them as experts on the research topic, emphasising my role as learner, and creating a non-judgemental and safe environment for them to share their opinions, thoughts, and experiences. Furthermore, I ensured that the interview took place at a time and date that suited the participant, ensuring that they did not have to take any kind of leave from work to participate in this study. I also provided financial compensation for any travel costs they had to incur to participate in this study. Furthermore, to ensure that the information and insights gathered in this study benefit all stakeholders, the results of this study will be disseminated, not only to the scientific community on submission of my thesis and scientific articles, but to the sample population as well. I will invite all caregivers, including the participants associated with the selected primary school, to attend a meeting where I will present the findings of the study and present an opportunity for discussion and questions.

Trustworthiness

Traditionally, the criteria of validity and reliability are used to assess the quality and rigour of quantitative research (Bryman, 2012). However, there has been concern about the relevance of these concepts to the establishment and assessment of the quality of qualitative research. As a solution, some researchers proposed a change in the meaning of the criteria (LeCompte & Goetz, 1982; Mason, 1996) while others have posited an alternative criterium, namely trustworthiness (Guba, 1985; Guba & Lincoln, 1994) to assess the quality of qualitative research. One major reason for the proposition of an alternative criterium is because reliability and validity presuppose that there are absolute truths about the social world. If one aligns with the paradigm of constructivism, however, one argues that there are several accounts of reality, thereby necessitating criteria that is inclusive of these different world views. Trustworthiness consists of five criteria of which each has equivalent criteria in quantitative research: (1) *credibility* corresponds with the concept of internal validity, (2) *transferability* equates to external validity, (3) *dependability* relates to reliability, and (4) *confirmability* is similar to objectivity (Guba, 1985; Guba & Lincoln, 1994).

Credibility and Truth Valu*e*

Establishing good quality research requires the demonstration of truth to foster confidence in the findings (Bryman, 2012). In quantitative research, this is shown by internal validity, which is the extent to which the evidence supports the causal link between variables in a certain context. In qualitative research, however, the feasibility or credibility of the outcomes determines its acceptability to others. This means that the data and the participants' perceived accounts should agree to a certain extent there should be a certain extent (Guba, 1985; Guba & Lincoln, 1994). One way of testing credibility is by means of respondent validation or member checking, a process by which the accounts of the researcher and participants are compared to determine the correspondence (Mays & Pope, 2000). The input of the participants is then incorporated into the findings, thereby reducing error. Member checking can be done either following data analysis or during the interview process. The former, however, may prove to be problematic in the low socio-economic context of this research study, as it is difficult to arrange follow-up meetings with participants. Consequently I employed the latter strategy during the interviews, referred to as spot member-checking (Mays & Pope, 2000). The spot member checks entail paraphrasing, asking probing questions, and follow-up questions to ensure that I correctly understand the subjective reality and accounts of the participants.

Transferability and Applicability

Another important criterium for good quality research requires that the findings should be applicable to other contexts, studies, or participants (Bryman, 2012). In quantitative research, this is established by means of external validity (Bryman, 2012). External validity refers to the degree to which the findings can be generalised to other contexts (Bryman, 2012). However, in qualitative research, research typically entails the in-depth study of a specific group of individuals in a specific context. It is inevitable that it would change over time and differ among milieus. Consequently, the aim is not to generalise the findings, but for each researcher to determine whether the findings of a study are applicable or transferable to their own research (Lincoln & Guba, 2013). Transferability is only possible through the thick and full description of the context of the research study. This would enable researchers to find similarities and differences between contexts, allowing for the possible transferability of findings from one context to another (Guba, 1985; Guba & Lincoln, 1994). Readers may obtain a full grasp of the context of the findings. By providing an in-depth description of the context, participants, and findings, readers may obtain a full grasp of the context of the findings, allowing them to assess the transferability of the findings.

Dependability and Consistency

In an effort to establish consistency and replicability in qualitative research, the dependability of the findings should be ensured (Guba, 1985; Guba & Lincoln, 1994). In quantitative research the concept of dependability and consistency corresponds with reliability, referring to the consistency of a measure in producing similar results under consistent conditions (Bryman, 2012). Reliability can, however, not be applied to the qualitative research instrument (i.e. the researcher) as the researchers themselves are dynamic and adaptive to the surrounding environmental factors and their subjective experiences. Thus, to establish dependability the research process should be thoroughly and meticulously recorded and described (Guba, 1985; Guba & Lincoln, 1994). By creating an audit trail, one could assess the evidence for the degree to which inferences from the findings can be justified. To ensure the dependability of my research, I have meticulously documented my ongoing research process in a research diary to give a comprehensive and truthful account of the steps taken throughout the study.

Confirmability and Neutrality

For the results to be confirmed and trusted, the conclusions and inferences should be clearly and objectively drawn from the data collected (Guba, 1985; Guba & Lincoln, 1994). This means that no personal biases, beliefs, values, agendas, or theoretical inclinations should influence the research process in any way. In quantitative research, a researcher attempts to reach objectivity by removing themself from parts of the process where they might influence the outcome, using standardised measures and so forth. However, from the theoretical viewpoint of constructivism, there is no such thing as true objectivity in qualitative research, as the co-constructed subjective reality of both the researcher and participant is inevitably influenced by personal factors (Lincoln & Guba, 2013). Therefore, it is not possible to demonstrate the objectivity of the researcher, but indeed possible to demonstrate the confirmability of the data itself (Guba, 1981). By clearly providing the protocol followed for data collection and data analyses, a researcher can demonstrate that the data collection was conducted in a scientifically accurate way (Guba, 1981). It is, however, essential for the researcher to be highly self-critical of how their own preconceptions might influence the research process (Leavy, 2014) and they should attempt to mitigate these influences by means of reflexive bracketing (Gearing, 2004) and reflexivity (Willig, 2008).

Reflexive Bracketing. Bracketing refers to the process whereby the researcher sets aside their prior suppositions, such as personal values, history, culture, and judgements, thereby mitigating its effects on the research process (Gearing, 2004). However, from the constructivist viewpoint, it is not possible for the researcher to be truly objective and separate from the phenomenon they are studying. Furthermore, a researcher wants to include overarching world suppositions, as this is foundational to the phenomenon under investigation. In reflexive bracketing, however, the aim is not to set aside presuppositions, but to thoughtfully identify them to reduce their influence or interference in the research and to create transparency in the research process. This type of bracketing typically occurs in the preparation stage, before data are collected, but can be reintroduced in the analysis stage (Gearing, 2004). This would allow the researcher to reassess their own assumptions following the insights gained from data collection and to become aware of new unconscious biases that may influence the data analysis stage. Consequently, I state my own biases below.

At the beginning of this study, I had some experience interviewing caregivers, children, and educators (in similar contexts as the present study) on matters of CAMH. My previous experience made me realise that there are fundamental differences in how caregivers and I conceptualise CAMH. I, as a childless researcher, thought about CAMH from an academic and theoretical point of view, while caregivers, who may lack formal education on CAMH, conceptualised CAMH through life experiences and practical knowledge. At the onset of the interviews with my participants, I was aware of the possible disconnect that may exist in our conceptualisation of CAMH and that neither is wrong or right. However, it was important to continually remind myself that caregivers did not lack an understanding of CAMH just because they could not express their understandings in an academic or theoretical way. I continually challenged myself through thought experiments by imagining how I would explain mental health concepts if I did not have formal education, realising how my own life experiences shaped my understanding of mental health. This helped me to bracket my formal education and theoretical background to understand how each participant's conceptualisation of mental health is unique and shaped by their own life experiences.

During my childhood, I also had my own, and vicarious, experiences of severe mental health problems. These experiences have shaped my own feelings and judgements about how a caregiver should or should not understand, recognise, and respond to a child's mental health problem. My approach to CAMH therefore grew from the point of view of a child, making it difficult to empathise with the view of a caregiver. Realising this discrepancy during data collection and analysis, I became aware of the judgements that I formed of the experiences and views of a caregiver. This awareness helped me to bracket my judgements, albeit imperfectly, to try and see the experience of CAMH from the viewpoint of a caregiver.

Furthermore, as my experiences with severe mental health problems created a major burden in my life, I view myself, to a certain extent, as being desensitised to the perceived severity of mental health problems. I therefore had to try and set these experiences apart as to not minimise the experiences of CAMH of caregivers.

Due to my own experiences with mental health problems and ongoing engagement with mental health support, I have made a personal choice in my life to normalise conversations about mental health and to advocate for engagement with mental health support. I have also recently come to terms with my own mental health journey. From this standpoint, I struggle to empathise with individuals' reluctance to acknowledge mental health problems and seek appropriate support. I continuously had to remind myself of a time in my own journey when I was reluctant to talk about and seek support for mental health problems. This allowed me to recognise and empathise with caregivers' self-stigma and fear of stigmatisation that is still pervasive in the South African context.

Reflexivity. Reflexivity is the process of constantly exploring the ways in which a researcher's involvement in a study contributes to, constructs and influences the research process (Willig, 2008). Reflexivity is an important process in qualitative research as it ensures that the researcher continuously reviews their position in research, both as a researcher (epistemological reflexivity) and as a person (personal reflexivity), and reflect on the ways in which it affects the research and its findings (Willig, 2008). The goal of reflexivity is for the researcher to recognise their own beliefs, values, experiences, interests, and identities and reflect on how it shaped the research study and how, in its own right, the research process has shaped us (Willig, 2008). In the following sections, I will cover aspects of personal reflexivity (my characteristics), epistemological reflexivity (demand characteristics), as well as a general reflection on the levels of data interpretation.

My Characteristics. During the research process, I was a white, childless, female researcher in my mid-twenties, representing Stellenbosch University. There is a possibility that my personal characteristics might have influenced the research process in several ways. Firstly, participants would often ask me whether I had children of my own. On the one hand, being a childless woman may have caused some participants to perceive me as unknowledgeable about parenting, making it difficult for them to identify with me and share their experiences as a caregiver. However, there is global narrative that womanhood is associated with motherhood, i.e., that women should want to have children and have a "maternal instinct" (Grill, 2019; Sennott & Mojola, 2017). On the other hand, participants may have over-relied on my ability to identify with parenthood, leading them to not explain their experiences to their full extent. Secondly, being white and of higher socio-economic status, participants identifying with other racial and class classifications may have related to me ways influenced by the racial and class divides and tensions caused by Apartheid that are still pervasive today. Lastly, considering that universities often conduct research in the communities from which the current sample was recruited, participants may have had previous experiences or assumptions about university involvement in communities. As I acted as a representative of the university, these previous experiences and assumptions might have influenced how participants perceived me and acted towards me.

Demand Characteristics. Demand characteristics in qualitative interviews refer to the participants' awareness of the topic the researcher is trying to explore or anticipates finding, and how this awareness then influences the participant with respect to how they think they should behave (McCambridge et al., 2012). Asking participants about their perceptions of their roles in their children's MH and MHS may have created some demand characteristics. Asking caregivers to participate in this study may have left them with the expectation that they are expected to have knowledge of their involvement in their children's MH and MHS, consequently placing them in the position of an expert. Placing participants in the role of an expert could make them feel as if they have to show their mastery of caregiver involvement. Similarly, I also felt expectations from the participants that I should know more about caregiver involvement and CAMH than they do. From their point of view, this expectation placed me in the position of an expert. While co-constructing reality in the interview, I attempted to make the participant feel that they were in the position of an expert to elicit their experiences, insights, opinions, and perspectives. However, our paradoxical expectations of one another regarding our expertise, may have contributed towards a certain power dynamic. Being childless and inexperienced in parenting, participants may have believed that I have less knowledge on parenting than they do, however, also being a researcher, participants may have expected that I know more about parenthood and CAMH despite their years of practical experience. This constant push and pull in the power dynamic made some participants formulate their responses to present themselves as competent and knowledgeable, while others were reluctant to share their thoughts in fear of providing the “wrong” answer or being judged. These reflections highlight how the position of researcher and participant in research can cause certain power dynamics which may, in turn, affect the data that can be collected.

Data Interpretation. The constructivist research paradigm assumes that there is no objective truth or reality, but that reality is rather continuously co-constructed and negotiated through conversation. Consequently, there are multiple points where the interpretation of reality can construe and shape the accounts of participants in this research study. Participants filter and select the things they share during an interview, which is what makes up their own interpretation of their lived experiences. I also then interpret the accounts of the participants (an interpretation of and interpretation). Furthermore, I interpret and discuss my understanding of the participants’ accounts in the context of broader literature. Although member-checking, as discussed before, attempts to ensure that my interpretations of participants’ accounts are indeed accurate, it is not a fool-proof strategy and mistakes may occur along the way. It is thus important to understand that the accounts of participants may be construed and shaped throughout the qualitative research process and that the end result may not be a complete representation of the realities of the participants.

Conclusion

In this chapter, I detailed the methods followed in this research study. The study followed an exploratory, qualitative research design. I purposively recruited Afrikaans and/or English participants who are the caregivers of at least one child (Grades 5–7) attending the selected school. I recruited participants by distributing informational flyers to Grade 5–7 learners at the school to give to their caregivers. Interested caregivers were then contacted to organise a date and time for an interview in a private venue on the school premises. Following informed written consent, I collected data using a semi-structured interview schedule and demographic questionnaire. Due to impact of the COVID-19 pandemic on my research process, I incorporated secondary data from a similar study to enrich my findings. Following verbatim transcription of the audio-recordings of the interviews, I used ATLAS.ti version 8 to thematically analyse the single corpus of data with a hybrid (inductive and deductive) approach. I received ethics approval and permissions from all involved stakeholders and, as far as possible, adhered to the principles of beneficence and justice. I also implemented several strategies to ensure the trustworthiness of the findings.

Chapter 5

Findings

Introduction

In this chapter, I present the findings of the current research study. The results section is structured around the four superordinate themes and 14 subthemes **(**Table 3**)** I identified during the analysis. The four superordinate themes were (1) “understanding of mental health terminology”, (2) “coping with mental health problems”, (3) “caregiver role in children’s mental health and wellbeing”, (4) “barriers/facilitators to caregiver involvement in children’s mental health and wellbeing”. In Theme 1, I provide a description of caregivers’ ability to articulate mental health definitions, derived by means of content analysis. I also provide a description the participants (Table 4).

Table 3

Overview of the Themes and Subthemes Identified

Theme	**Subtheme**
Understanding of mental health terminology	Description of mental health Presentation of mental health problems Causes of mental health problems Maintaining mental health
Coping with mental health problems	Avoidance Seeking emotional support Gestures of comfort Talking it through
Caregiver role in children’s mental health and wellbeing	Caregiver as guide and provider Caregiver-child relationship and support
Barriers/facilitators to caregiver involvement in children’s wellbeing	Systemic / structural Attitudes and beliefs regarding CAMHS Knowledge and understanding Family and community circumstances

Participant Description

I interviewed a total of 31 participants, as part of two separate studies. Participants were on average 45.29 years old (SD=10.961), female (83.9%), Afrikaans-speaking (96.8%)

and the biological parent of the child of interest (child that meets inclusion criteria, i.e., Grade 5–7) (67.7%). The participants' level of education and employment status varied considerably, with the majority having matriculated (32.3%) and being employed full-time (38.7%). A detailed outline of the participant demographics is available in Table 4.

Table 4

Participant Demographic Information of Study 1 and Study 2

	Study 1 (n=10)	**Study 2 (n=21)**	**Total (n=31)**
Age			
Mean (standard deviation)	39.90 (7.36)	47.86 (11.59)	45.29 (10.961)
Gender			
Female	8 (80%)	18 (85.7%)	26 (83.9%)
Male	2 (20%)	3 (14.3%)	5 (16.1%)
First Language			
Afrikaans	10 (100%)	20 (95.2%)	30 (96.8%)
Other		1 (4.8%)	1 (3.2%)
Highest Level of Education			
Primary	2 (20%)	5 (23.8%)	7 (22.6%)
Grade 9	6 (60%)	1 (4.8%)	7 (22.6%)
Grade 12	2 (20%)	8 (38.1%)	10 (32.3%)
Tertiary	-	7 (33.3%)	7 (22.6%)
Employment status			
Full-time	7 (70%)	5 (23.8%)	12 (38.7%)
Part-time	1 (10%)	2 (9.5%)	3 (9.7%)
Unemployed	2 (20%)	5 (23.8%)	7 (22.6%)
Retired	-	2 (9.5%)	2 (6.5%)
Unknown	-	7 (33.3%)	7 (22.6%)
Relationship to Child			
Biological parent	8 (80%)	13 (61.9%)	21 (67.7%)
Legal guardian	2 (20%)	8 (38.1%)	10 (32.3%)

Theme 1: Understandings of Mental Health Terminology

Introduction

Participants had difficulty to articulate their understanding of the mental health terminology during the interview. By means of a content analysis, I discovered that 23 of the 31 participants (74.19%) could not articulate a definition for at least one of the mental health terms asked. As such, close to a quarter of participants could articulate an understanding of all mental health terms.

In the instances where participants indicated that they did not know the meaning of a term, further probing led to some answer about three quarters of the time. Probing questions, reassurance, and encouragements, such as "*How would you explain the word to your child*?", "*What do YOU think it means*?", "*There is no right or wrong answer*", and "*I want to hear what you think*" usually elicited some description from the participants. Even participants who attempted to articulate their understanding of the words sometimes required further encouragement for a more detailed description.

Participants' answers were analysed thematically, and I report on them here under the theme "understandings of mental health terminology". The answers participants provided were often grounded in their own and others' experiences with mental health problems, with only some conceptualisations being specific to their experiences with children. These recollections provided some information on their understanding of the description, presentation, causes and maintenance of mental health. Table 5 shows the mental health terminology asked during the interview and the percentage of times an answer was given. The table also shows examples of answers given, categorised according to the description, presentation, cause and consequence, and maintenance of mental health. As can be seen in Table 5, participants offered the same answers for many of the terms given. As such, there is considerable overlap in participants' understandings of the various terms.

Table 5

Overview of Participants' Answers when Asked their Understanding of Specific Mental Health Terminology

Mental health terminology asked during interview	**Times (%) an answer was given**	**Subcategories of answers**	**Examples of answers given**

Emotional health	83.3	Description	How you feel every day
		Presentation	-
		Cause and Consequence	If you don’t talk you become ill
		Maintenance	-
Emotional health problem	52.6	Description	How you feel every day
		Presentation	He’s a completely different person
		Cause and Consequence	-
		Maintenance	-
Mental health	65.5	Description	It’s something in the brain
			How you feel every day
		Presentation	Going crazy
		Cause and Consequence	If you don’t talk you become ill
			What I went through
		Maintenance	It’s the balance
Mental health problem	37.5	Description	It’s something in the brain
		Presentation	Going crazy
			When you see a psychologist
			He’s a completely different person
		Cause and Consequence	If you don’t talk you become ill
			What I went through
		Maintenance	Taking medicine
Psychological health	90	Description	It’s something in the brain
		Presentation	When you see a psychologist
		Cause and Consequence	If you don’t talk you become ill
			What I went through
		Maintenance	It’s the balance
Psychological health problems	73.3	Description	It’s something in the brain
		Presentation	He’s a completely different person
		Cause and Consequence	If you don’t talk you become ill
		Maintenance	Taking medicine

Note. In the column titled “examples of answers given”, a “-” means that there were no responses in reference to that specific subcategory of answers.

Due to the considerable overlap in the meanings of different mental health terminology, it is sensible to focus on participants’ understanding of the terminology, rather than the terminology itself. Consequently, I will subcategorise the findings of Theme 1 according to the different answers given, i.e., “description”, “presentation”, “cause and consequence”, and “maintenance”, as displayed in Table 3. In each of these subcategories (a.k.a. subthemes), I will elaborate on the findings pertaining to these categories and make mention of the specific mental health terminology associated with the findings.

Descriptions of Mental Health Terminology

When asked about the meaning of the terms “mental health” and “mental health problems”, participants described it either as an illness or the experience of every-day emotions.

Participants described “mental health problems” and “psychological problems” as an illness, characterising it as “*something in the brain*” or a “*disorder of the chemical compositions in your brain*”. Participants referred to depression, anxiety disorders, schizophrenia, and bipolar disorder as examples of mental health and psychological problems. One participant described what mental health problems are:

> *“I know it’s a chemical imbalance or something in the brain that doesn’t gel nicely and that causes problems like uhm what- you get bipolar disorder or schizophrenia” – I001P*

Participants described “emotional health” as the everyday emotions you experience in response to normal daily events, often due to social interactions with others. These every-day emotions are also said to change from day to day and in response to different situations. One participant describes the everyday emotions associated with emotional health:

> *“…that is how you feel like how uhm- do I feel happy today am I feeling full of stress again today or am I feeling tearful again today it’s all linked to emotions how you feel every day” – R009P*

Participants also described “mental health” as one’s everyday emotions; however, these emotions were described as private feelings that others cannot see or notice, and therefore quite different from everyday emotions described previously. One participant describes the private emotions associated with mental health:

> *"...a thing that goes on inside a person- what type uh yes- is more about your feelings inside that no one can see how you really feel inside" – R011P*

Presentation of Mental Health Problems

During participants' explanation of their understanding of the terms, participants also reported on how they recognised mental health problems in others. Participants reported that, for them, certain behaviours, and the use of mental health services were tell-tale signs of someone experiencing mental health problems.

Participants reported that mental health problems among both children and adults were associated with abnormal or socially unacceptable behaviours, such as yelling at others, fighting, obscene language, disobedience, or abusing and manipulating others. Participants described these actions as "*going crazy*", "*flying off the handle*", "*taking crazy pills*" or "*bewitched*". Such actions were often said to be outside of the control of the person exhibiting them. One participant explained their own experience with overwhelming feelings of anger (associated with experiencing mental health problems).

> *"You just want to attack people you just want to you just want to talk loudly you just want to scream you want to- you don't even have the uhm courage to talk you just want to climb in to another's chest and rip it apart" – S007*

Some participants also reported that in their experience individuals with "mental health problems" displayed upsetting and possibly psychotic behaviour, such as suddenly not recognising others, suicidal behaviours, paedophilia, and visual and auditory hallucinations. One participant recounted an experience with an acquaintance exhibiting psychotic behaviour:

> *"I don't know what he saw but he just saw a bunch of animals and he started chasing the people all of them tried to stop him he also chased his mom at home" – R010P*

Not only did participants recognise mental health problems in others from socially unacceptable behaviours, but also by sudden changes in their behaviour. Referring to their experiences with their own children, participants explained that when a child becomes quiet and withdrawn compared to their usual outspoken and outgoing selves, it might be a sign of a mental health problem. One participant described how to recognise mental health problems in children:

> *"Every parent knows their child if the child was spontaneous and the child is suddenly not spontaneous anymore so something is wrong there is a problem" – S006*

Participants also reported recognising "mental health problems" and "psychological health" by the fact that someone is receiving mental health care in the form of counselling or medical treatment. Despite the connection participants made between mental health problems and receiving treatment, many participants struggled to define the term "mental health services". One participant had difficulty explaining what mental health services meant to them:

> *"Mental health services (laughs) I won't be able- because I don't know what they do or what the technique is that they use look we weren't present you see" – S006*

However, a few participants associated mental health services with seeing psychologists, psychiatrists, the NGO located at the schools, as well as church leaders.

Causes and Consequences of Mental Health Problems

When explaining their understanding of mental health terminology, participants mentioned their beliefs about the causes of mental health problems. These causes included external factors, such as experiencing trauma and living in a challenging and difficult environment, as well as internal factors such as the suppression of emotions.

Participants reported that problems associated with “mental health”, “mental health problems”, and “psychological health” are caused by the experience of traumatic incidents, such as abuse, domestic unrest, and bullying. Such traumatic incidents were often described as having occurred during childhood, but staying with one throughout one’s life.

> *“If something maybe happened in your earlier time maybe in your life and you can’t get past it then you need psychological help because it it devours you” – R009P*

Participants also explained that “mental health problems” among children were caused by undesirable living circumstances, including an unsafe home and community environment as well as certain socio-economic factors (such as poverty).

> *“Many children pick up such things [mental health problems] at home [...] because the circumstances the environment they are in a lot of the time it’s also I wouldn’t say things that happen at home they live in an area where- it’s the neighbour it’s this person it’s that person” – SIM004*

Participants expressed that for both adults and children, supressing unpleasant emotions (often resulting from trauma), instead of sharing these with trusted individuals, could “*make you ill*” and have several consequences. These consequences included (1) emotions becoming overwhelming and difficult to bear, (2) making it difficult to maintain social relationships, and (3) engaging in self-destructive behaviour, such as mixing with the wrong crowds, abusing drugs and alcohol, smoking, violent behaviour, and risky sexual activities. One participant describes the overwhelming consequences of suppressing emotions:

> *“People don’t talk about their feelings and what what’s important or what- things that hurt them and then you get that knock and then you sit with this problem and at the end of the day then then it becomes so great that you can’t deal with it on your own” – R013P*

Maintaining Mental Health

When providing their understanding of mental health terminology, participants shared several strategies for maintaining good mental health. Such strategies included leading a balanced life, managing one's emotions, and treating mental health problems with medication.

Participants explained that to maintain good "mental"- and "psychological"- health, for both adults and children, you should lead a balanced life. Leading a balanced life was described as feeling content and managing your attitude towards life, practicing religion and participating in religious activities, eating healthy, and being authentic in one's social relationships. One participant explained how to be content and maintain good mental health:

> *"I think it means to feel happy to not feel anxious to know how to handle your emotions I think it's- but yes basically uhm to feel content every day that is mental health" – I001P*

Participants reported that "emotional", "mental", and "psychological health" are all associated with how well you understand your own emotions and how able you are to manage your emotions in reaction to life events. One participant explained the consequences of not being able to manage your emotions:

> *"You're angry but you don't know how to express that anger you have that anger you don't know what to do with it and now a mixed feeling came through and you don't know what to do with it" – R002P*

Participants reported that mental health problems among individuals are easily treatable with medications like injections and pills administered by healthcare professionals.

> *"...almost like one who becomes ill you hear voices you see people that want to hurt you all those things and when you get treatment all of those things go away" – R001P*

> *"We would help his wife get him to the hospital [...] they sometimes just [give] the injection to get him calm [...] then he gets his first dose of medication but then they send him home"* - *R003P*

However, participants emphasised the importance of taking such treatments on a regular basis to maintain normal functioning. Otherwise, one's mental health problems become visible or noticeable to others. One participant described the cycle of non-adherence to medication:

> *"The cycle keeps repeating with him not having that medication and on medication he's a quite normal healthy guy quite irie ((meaning cool, at peace))" – R003P*

> *"You get treatment for it then you have to use the medication and stay on the stuff the doctors or whoever prescribes you then you can lead a normal life" – SIM005*

Theme 2: Coping with Mental Health Problems

Participants recounted how their families deal with mental health problems. Despite participants finding it easier to report on their coping mechanisms than their understanding of mental health terminology, there was little to no differentiation between the strategies applied to address "mental health", "emotional", and "psychological problems" as separate issues. Consequently, in this section, I report on the strategies applied in general when dealing with mental health problems.

Avoidance

Participants indicated that they did not feel confident in dealing with their children's mental health problems at home or providing the necessary emotional support. In addition, many reported not having sufficient support systems when dealing with mental health problems. One participant described their lack of knowledge about their child's mental wellbeing:

> *"I as parent I'm not schooled in psychological attitudes of how a child develops I wouldn't know how to handle him or her" – SIM006*

The lack of knowledge and support in dealing with mental health problems in the family often leads to participants avoiding the problem altogether. One participant reported how their family dismissed emotional problems:

> *"I think as a family we don't really show our emotions as a family so there aren't many times that we actually have to deal with emotional I think the same with mental health problems it's kind of dismissed 'oh get over it' 'don't take it to heart' something but I think mostly yes it's just avoid or or to get over it as quickly as possible" – I001P*

Participants reported that children were often left to deal with their problems on their own due to avoidance of problems at home. This was especially true for the expression of anger, which is either ignored or discouraged at home. The family would then resume usual interactions once the child has "*cooled down*". The avoidance of anger was especially evident in cases where the anger originated from a source outside of the home context, for example, an argument with a neighbour. One participant described how their family deals with a family member's feelings of anger:

> *"Well we ignore it (laughs) because if you're angry then you have to be angry and get over it and yes because that's how we my family we deal with it like that we didn't make you angry so it's not necessary to be angry with us so then we ignore him the one then after a while he decides it's not worth it being angry so then he's fine again like one would say" – I003P*

Seeking Emotional Support

In contrast, participants who reported having a good support structure would often engage with that system when they feel ill-equipped to handle their children's mental health problems at home. These support systems consisted of other family members, friends, church members and leaders, and colleagues. One participant described how they confide in colleagues:

> *"You don't always have an answer then it's- I usually go talk to my colleagues how do you experience it my one colleague also have children and then we usually talk to each other how did you deal with this that's how- psychologically wise, I try to sort it out in such a way" - I007P*

Despite the availability of support, some participants felt confident in dealing with mental health problems in their family unit and preferred to do so. One participant explained that the family does not need outside support:

> *"We sort it out ourselves, to me it feels like I don't need it (mental health services) because I can handle them myself and our family has never been that bad that we couldn't handle it you see so for me it's actually not a problem I sort it out myself" – SIM001*

Gestures of Comfort

Participants reported using multiple strategies to provide emotional support to their children, including reassurance, consoling and comfort, distraction, and religious practices.

Participants described that when children were experiencing feelings of sadness or fear, they would attempt to make the children feel better by reassuring them of their support, consoling and comforting them with physical gestures (such as hugs or pats), providing words of affirmation, or simply being present. Reassurance was described as a strategy to build trust and encourage children to talk about their feelings. One participant reported how they would assure their child if they felt scared:

> *"...and she was actually scared to talk to me but then I assured her 'I'm here to help you I'm here to be with you I'm here to support you nothing's going to happen to you you're going to be okay' she could talk to me and she could tell me" – R002P*

Participants also detailed the use of distraction in dealing with children's emotions. Participants explained that using strategies such as humour, playful teasing, and engaging in fun activities, distracted children from their unpleasant emotions and made them feel better. Distraction was described as the preferred tactic when the problem was not in the control of the child or caregiver. One participant gives examples of activities used to distract children from their feelings:

> *"When they're unhappy then I just take them- we go for a walk or we climb on our bicycles then we go for a ride and then we just talk that's it and then when we get back he's happy again" – SIM009*

Some participants reported that they would turn to religious activities, such as praying or attending religious gatherings, as a way of dealing with children's emotions. One participant explained how they rely on faith to deal with feelings of fear:

> *"Usually we will fall onto our faith and I will try and explain to them why they don't need to feel scared and we have a prayer that specifically deals with when you feel scared so we will then pray together" – I001P*

Talking it Through

The most salient coping mechanism for dealing with problems at home participants reported was "talking it through". According to the participants, the process entailed allowing the involved parties, including the children, time to "cool down" and process the issue in private before discussing it as a family. Conversations were then held after the child had indicated that they were ready to address the issue. One participant explained how they would take time to process and manage emotions before discussing the problem:

> *"We have psychological problems every now and then we handle it we deal with it- maybe for a day or two we won't talk but at the end of the day we talk I would rather wait let it 'okay you're angry now I'll wait first for a*

> *day or two let you cool down until you know you're going to- let's chat' then we talk about the topic whatever the topic was"* – R010P

Once the child is ready to engage in conversation, the family would share, explain, and discuss the problem, and then find ways to problem solve or modify or compromise on unwanted behaviour.

> *"...then we go for a walk then we'll maybe go sit in the park sit there on the swings and then we chat then she fights with me and she cries if she wants to cry and she says things she wants to say and she whatever- but at least I know it's out [...] but I want you to tell me what you're feeling and you have to we have to understand each other afterwards if there's something that I'm not satisfied with then I also go walk with her and then the two of us chat"* – I006P

Although some participants felt that children were unwilling to talk about their feelings or problems, participants reported that they would encourage their children to express their feelings to those they trusted.

> *"I also always tell them if you don't want to talk to mommy then talk to a friend or someone or or another adult who you know will keep your secret but but let it leave you talk to someone so that you can feel better"* – SIM006

Participants encouraged children to talk about their feelings because from their own experience, sharing one's feelings with others brings about a sense of relief and calmness and creates an opportunity for others to listen and give advice.

> *"When you share with someone then that person can give you advice and when he is done giving you advice then you actually feel oh wow but it was actually not that bad"* – SIM005

While participants felt strongly in favour of open communication and encouraged their children to talk openly and honestly about their feelings, they were seldom able to do so themselves. Participants explained that their children were aware of their emotions and would ask them about why they were feeling sad or angry, but they were reluctant to engage their children in conversations about themselves.

> *"My children can't handle it when I'm crying so I'm not going to cry in front of them so I will- when I'm feeling like that in the moment- which doesn't happen that often- I will go to the bathroom turn on the tap that it seems like I'm doing something in the bathroom and then use that 5 to 6 minutes just to calm down" – SIM004*

Participants explained that hiding their feelings from their children was motivated by the fear of seeming weak or by wanting to protect the children from the cause(s) of their feelings, such as stress over finances.

> *"I'm also not a person who wants to be emotional in front of my children all the time because a parent doesn't always want the child to see the weak part of the parent" – SIM006*

Theme 3: Caregiver Role in Children's Mental Health and Wellbeing

In addition to how caregivers understood and managed their own and their children's mental health, they also reported on what they thought their caregiver role is in their children's mental health. Many participants equated their role in children's mental health to the general duties of a caregiver, such as developing their moral compass, providing a better life, and loving them. However, other participants spoke directly to their role in their child's mental health, emphasising the importance of spending time with children and providing support.

Caregiver as Guide and Provider

Participants explained that it is the role of the caregiver to develop their child's moral compass by teaching them right from wrong. Concepts that participants felt were important to convey to their children included respect for others and your elders, navigating social conflict, caring for those younger than you, and general manners.

> *"I tell him [name of child] you don't know who is older than you you have to respect your elders respect your friends"* – SIM008

Participants reported caregivers should act as an advisor and role model to instil these values, making their children aware of the consequences of their actions and setting the example for how they wish their children to behave.

> *"He will come complain if he has a problem because I will always listen and I will tell him but you have to do this you have to do that and these are the consequences if you're not going to listen to me"* – SIM002

Participants reported that as a caregiver, it was their duty to provide their children with a life better than the one they had or, in the case of children put into their care, what the child was previously exposed to. Providing a better life entailed providing their children with necessities such as food, shelter, healthcare, schooling, toiletries and ensuring they are safe and happy.

> *"...and I feel like it's a delight because I feel like her mom has only been dead three years and I had the need to adopt her and take her in to give her a better future"* – SIM003

Participants reported that simply "*loving*" a child is an important part of their upbringing and for the future of the caregiver-child relationship. Participants explained that rejection, yelling, verbal and physical abuse, degradation, pressure, and distrust are all contrary to a healthy and loving relationship with your child.

> *"It's all your love, sacrifices, your dedication as a parent. That child did not miss it and today he appreciates- because he's grown up and a father himself- now he appreciates what I did for him as a parent"* – SIM005

Caregiver-Child Relationship and Support

Participants expressed the importance of spending time with one's children. Participants reported that, on average, they would spend between one and five hours with their children per day. When asked what activities they did with their children, participants reported a wide variety of activities, including listening to music, reading, playing games and sport, church activities such as choir or theatre, schoolwork, chatting, watching television, baking, and having meals together. Participants noted that it was important to make time for such activities, despite other home and work responsibilities.

> *"no you're not too busy doing your things so don't tell your child that you're busy- then make- tell her 'okay give mommy 5 minutes or 10 minutes then mommy will listen to what you have to say'" – SIM001*

Participants reported that spending time with children is essential for building caregiver-child relationships, getting to know one's children, and promoting communication. Participants also stated that a good relationship between a caregiver and their child enables them to recognise when there is a change in behaviour that might indicate a mental health problem that should be addressed.

> *"A lot of children won't easily talk when there is something wrong with them if you as parent know your child then you will know no my child is not themself today there's something else that is bothering them or something" - SIM004*

Furthermore, participants also felt that every child should be treated according to their individual needs and personality. Consequently, knowing your child well will enable you to adjust your approach to fit that child.

> *"Everyone has different personalities different parents different backgrounds so every child needs to be handled differently" – IR001P*

Participants reported that it is a caregiver's responsibility to provide children with consistent support by showing them that you are there, building their self-esteem, being involved, and interested in their activities and providing help when it's needed in the achievement of their goals.

> *"If he know his parents are standing behind him one hundred percent [...] no matter what your circumstances in life are show- just give that child that footstep that he just knows he has a parent behind him or parents- that he can achieve what he wants"* – SIM002

Participants expressed that without caregiver involvement, a child would be unable to achieve their goals. Furthermore, participants reported that a lack of involvement would cause an irreparable rift in the relationship between caregiver and child. This breakdown in the relationship would leave caregivers unable to guide and influence their children, ultimately leading to undesirable outcomes, such as absconding from school, the abuse of drugs and alcohol, gangsterism and poverty.

> *"I make sure I'm there, or if there's rugby, I go watch, because tomorrow my child sees my dad- my parents are interested in the things I do, they support me, but if you are not going to provide support to your child, tomorrow or the next day, where's he then? He's on the streets"* – SIM009

Theme 4: Barriers/Facilitators to Caregiver Involvement in Children's Wellbeing

Despite the participants' beliefs about their caregiver role in children's mental health as discussed in Theme 3, participants felt that they face many ongoing challenges that make it difficult to fulfil these responsibilities. Participants reported on barriers/facilitators associated with the system, attitudes and beliefs about CAMHS, knowledge and understanding, as well as family and community circumstances.

Systemic / Structural

Many participants felt that they do not always have the financial means to provide their children with the support they need or to provide them with a life better than they had had. Examples given entailed giving "pocket money" to children, providing enough food, toiletries, and clothing, participating in school activities, paying school and crèche fees, providing additional learning aids such as computers, as well as providing psychological help for their children.

> *"The grant money he gets his monthly expenses are over that total I- I mean they have to eat they have to get dressed my husband and I are the only ones working and so on our money goes directly into that [...] the money isn't for me I wanted it for my children to create a better life for them that's actually what it's about – SIM005*

Attitude and Beliefs Regarding CAMHS

Overall, participants had very little experience with mental health services and had no expectations for such sessions. Participants generally felt that the problems they were facing did not warrant engaging with mental health services as they did not deem their issues serious enough.

> *"She hasn't been a problem yet [name of child] hasn't been a problem it was only that one incident that we had and- so we- I tried to handle it from my side I sat and talked to her and it was solved so she hasn't had a problem" – SIM005*

Despite their reluctance to engage with mental health services, participants indicated that they would not discourage their children from seeking help if they wished to do so. However, participants felt that their children should have a good reason to attend such services, as children only want to attend for social reasons.

> *"You should go because you want to go and for a good reason and a right reason for why you want to be there you can't go after your friend just because your friend is going" – SIM001*

However, many participants indicated that they joined the study looking for help with problems they had been experiencing with their children, guidance on recognising problems their children might be having, emotional support, parenting and relationship advice. This indicates that participants may indeed have a need to engage with mental health services.

> *"I read the form, called my son and also asked him what he thought about it and he said it's something good and it's actually to help me because many times you feel, especially as a non-biological parent, there is something that you're failing at and you need someone's help to show you the right way" – SIM005*

Participants who had had previous experiences with mental health services (CK, appointed social workers and other mental health services) did so by referral rather than by actively seeking help themselves. These participants came to acknowledge the importance of cooperation, i.e., a therapeutic alliance. Participants valued being an active agent in their children's therapeutic process to bring about positive change. Participants appreciated consistent communication between child, caregiver, and mental healthcare professional to the benefit of their child.

> *"It's important yes it's- look, then it's almost like you understand each other better you see? Then I know what they know and they know what I know so then we make a team, you see? We all communicate with each other, you see? [...] then what they discuss, I am also part of it, just like [NGO] are also going to be part of what we discuss, you see? Then it's almost going to be like whole team and it works" – SIM001*

Furthermore, participants reported that the biggest advantage of engaging with mental health services is the knowledge and personal growth through the process. Participants especially emphasised their own growth through their children's engagement with mental health services. The skills and knowledge gained often included correcting parenting styles, how to recognise problems their children are experiencing, insight into the motivations behind their child's actions, how to build a relationship with their child, and how to be supportive of their child who is engaged in therapy.

> *"It was a learning process a new experience [...] I learnt things by it and it made me more- it is- since then I have been more attentive towards children, not just mine, even other's, or even when I'm in a conversation with a parent" – SIM006*

Participants whose children had engaged with mental health services often reported positive experiences and good therapeutic results. Participants felt mental healthcare professionals had the ability to "*open up*" their children, providing a space to talk about their problems.

> *"I sent my daughter to a psychologist because she didn't want to talk but I knew there are people who would be able to make her talk" – SIM006*

Knowledge and Understanding

Participants reported difficulty in recognising mental health problems in their children and lacked the knowledge to deal with such problems. Specifically, participants acknowledged that their children's feelings and problems were not always clear. Even if their children's troubles were noticeable, participants expressed that it was difficult to encourage their children to openly share such feelings with them.

> *"He's a guy that doesn't easily talk to me- he's he's one that keeps things to himself so- that's a closed book that is a closed book that I'm still trying to open I don't know how but I will have to work out- a way to see how I will solve that problem because if you can't talk to your mom then I don't know then it's a problem" – R007P*

Additionally, participants found it challenging to distinguish between normal teenager behaviour and signs of mental health problems, such as with changes in behaviour, decreased communication, mood swings, and sexual conduct.

> *"We didn't notice anything and we accepted that that was just the type of person he is and that he is a withdrawn person who doesn't communicate a lot so it wasn't a problem for us he was a person on his own until we heard what really was going on" -SIM006*

Participants indicated that even if they had recognised that their children required further mental health support, they were unsure of how to provide emotional support. Participants were also not familiar with the available mental health services in their community, such as the NGO at the schools their children attend, or were unsure of the procedure to engage with such services.

> *"(it would help me) If I knew exactly how to handle them (children's emotions) or what to do if something happened what steps I as a parent have to take to make sure things don't get out of control" – SIM006*

Participants expressed that they felt ill-equipped in managing and mitigating the negative influences associated with the community in which they live, including violence, inappropriate behaviour, bad parenting (in the case of caregivers), and bullying.

> *"I teach my children very well at home. They're not allowed to swear, but outside it goes on you can't stop it outside you can stop it at home but not outside because there are a lot of children who does it and say it" – SIM001*

Family and Community Circumstances

Participants described how difficult it was to make time for their children due to their many responsibilities. Between work responsibilities and household duties, such as preparing food, cleaning, and preparing children for bed/school, participants reported that they have little time and energy left to spend on helping children with homework, attending school activities, or spending quality time with their children, which, in the participants' opinions, leads to children feeling neglected.

> *"But then there is always that special time what you as parent can't give your child because when I come from work then it's cooking you have to do this you have to do that so it's not like everyone can make that time to go and sit with that child" – SIM004*

The difficulty to find time was often exacerbated by family structures and dynamics. Participants expressed that being a single mother, having an uninvolved partner, and/or marital problems further interfered with their ability to tend to their children's emotional needs.

> *"I am a single parent sometimes things become too much the school maybe needs this and we need this at home you need this at the end of the day it's almost like I have to split myself in two" – SIM002*

Additionally, participants' own emotional needs and/or trauma were often said to hinder them from fulfilling their caregiver role in their children's mental health.

> *"It's not just the children who have such problems, like I said, the dad already has a history" – SIM006*

Conflict would sometimes arise between caregiver/legal guardians and the biological parent about how children should be raised and treated. Despite the involvement of social workers, participants (caregivers) reported feeling helpless, as they do not want to/could not deny the children contact with their biological parents, even though this would at times mean exposing the child to verbal and/or physical abuse.

> *"She will just slap him or hit him [...] but I say 'you don't do it you don't do it that's not how we are raising him you don't hit him not like that you don't do it that's not a parent's #%$'" – SIM005*

Participants were willing to seek emotional support and advice from their social group (church members, clerics, family members, and colleagues) when confronted with parenting and marital problems. Participants reported feeling relieved once they had expressed their feelings and experiences to others. While some participants preferred talking to trusted peers, others preferred entrusting strangers with their feelings. Indeed, the need for personal support was often cited by participants as the reason they participated in the current study.

> *"...you just feel a bit relieved because there was someone to talk to about it" – SIM001*

However, participants reported that they often lack the necessary emotional support structure to share their feelings in a safe and confidential manner. Participants often feared that the person in whom they would entrust personal information would break their trust and confidence.

> *"...yes what you give now is confidential you know it's going to stay with that person he is going to give you advice and he's going to pray for you he will pray with you over the problems but he won't go and spread it" – SIM005*

Some participants felt that distrust was especially a problem in their community, which often leads to a break-down in relationships and diminishment of a viable support system. Participants expressed that when there is a breakdown in a relationship, confidential information would often be weaponised to "*get back at the person*".

> *"It regularly happens amongst us Coloureds [...] many of us begin to withdraw from our people, do you understand? because we don't trust each other. I can't share a deep secret with you because after a while [...] when the friendship is gone then that person wants to spread what we shared with each other to get back at me [...] people don't trust each other enough to share deep things" – SIM006*

Conclusion

In this chapter, I reported on the findings of this research study, which included four subordinate themes and 14 subthemes. The findings report on how caregivers understood mental health terminology and how they cope with mental health problems at home. How caregivers perceive their role in their children’s mental health and the barriers and facilitators they face in this role is also reported in this chapter. A detailed summary of the findings are presented in Chapter 6.

Chapter 6

Discussion

In this study, I sought to explore the involvement of caregivers in their children's MH and MHS by means of qualitative, semi-structured interviews. Using reflexive thematic analysis to analyse the resulting data, I identified four major themes (with 14 sub-themes), that provided insights on caregivers' (1) understanding of mental health terminology, (2) coping with mental health problems, (3) caregiver role in children's mental health and wellbeing, and (4) barriers/facilitators to caregiver involvement in children's wellbeing.

In Theme 1, I reported on caregivers' understanding of mental health terminology. Caregivers struggled to communicate their understanding of common mental health terminology. However, those who did convey their understanding, described mental health problems either as a biological illness or the "normal" range of everyday emotions. Mental health problems were often said to present as unacceptable or psychotic behaviour, a sudden change in behaviour, or by accessing mental healthcare. Participants believed that mental health problems were either caused by experiencing trauma, undesirable living circumstances, and/or the suppression of emotions. To maintain good mental health, participants made use of strategies such as leading a balanced life, managing emotions, and using psychiatric medication.

In Theme 2, I presented the strategies the participants employed in dealing with their children's and their own mental health problems. Participants who were unsure of how they should respond to mental health problems often avoided the issue altogether, while other participants would seek emotional support from their social network. Participants also made use of gestures of comfort, including reassurance, consoling and comfort, distraction, and religious practices to support a child experiencing emotional or mental health problems. Participants also emphasised the importance of dealing with a child's emotional or mental health problems through voluntary, open, and honest conversation, but seldomly did so with their own issues.

In Theme 3, I reported on how caregivers understood the role they play in their child's mental health. Many participants equated this role to general parenting practices, such as developing children's moral compass and social skills, emphasising the importance of respect, resolving social conflict, caring for those younger than you, and general good manners. Speaking directly about mental health, participants explained that their role was to be involved in a child's life and building a good caregiver-child relationship, as this would allow you to identify potential problems and have the trust of your child to support them.

Theme 4 describes caregivers' perceived barriers and facilitators to being involved in their children's MH and MHS. Participants discussed the impact of poverty on meeting children's mental health and general needs. Participants explained that their current situations were not "serious" enough to engage with mental health services but admitted that they joined the study in the hopes of gaining knowledge and support. Participants who had engaged with mental health services reported good experiences and emphasised the skills they have gained. Participants expressed their difficulty in identifying mental health problems among their children, and even if they did, they would not know how to support their children. Participants also described how their ability to be an involved caregiver were often hampered by other home and work responsibilities, difficult family structures and dynamics, and their own emotional needs and/or trauma. Although some participants expressed the value of seeking support from their social network, others lacked such a network or felt that the lack of trust and confidentiality within their community hindered them from making use of the network.

Caregivers’ Understanding of Mental Health Terminology

Participants in this study struggled to articulate their understanding of mental health terminology. Indeed, 74.19% of the participants found it difficult to provide and explanation for all of the mental health terminologies asked during the interview. Several rounds of probing, follow-up questions, and reassurance was necessary before the participants were able to conceptualise and articulate their understanding of these terms. The participants’ inability to articulate a description of mental health terminology is not unique to the participants in this study. For example, in the non-systematic review by Furnham and Swami (2018), the authors pointed out that lay individuals often struggle to use correct psychiatric labels. Participants’ difficulty with mental health terminology might be due to several reasons. Firstly, participants could have limited or poor mental health literacy. In other South African studies, such as Hugo et al. (2003) and Kometsi et al. (2020), authors have found that the general population showed poor mental health literacy. However, a lack of articulation of the mental health terminology does not necessarily mean a lack of understanding of these terms. By this I mean that caregivers may have a cultural or contextual understanding of mental health terms but may lack the vocabulary to describe these understandings (Backe et al., 2021; Lichtenberg et al., 2021). Secondly, the power relationship between the researcher and participants could have contributed to participants’ reluctance to share their conceptualisations of mental health terminology (Karnieli-Miller et al., 2009). Simply, participants could have feared sharing their thoughts due to perceptions of being tested by the researcher or feeling intimidated to provide an answer to me, a researcher they deem to be an expert in the field of mental health. Although the strategies I followed, such as rapport building, reassurance, and affirmation helped to mitigate the power relations between the research participants and I (Anyan, 2015), it does still bring into question the way we frame, structure, and ask questions concerning mental health. It might be beneficial for future researchers to ask individuals’ understandings of mental health terminology indirectly, for example, through the use of case vignettes (Jorm et al., 1997), to promote a more conversational and relaxed response.

While understanding participants’ knowledge of the causes of mental health problems was not a specific aim of the study, the analysis of the data showed that participants prescribed to various explanatory models. Similar to a sample of Haitian parents (Lichtenberg et al., 2021), participants in this study prescribed to a psycho-social explanatory model, citing that the experience of trauma and/or living in poverty is often the root of mental health problems. Mirroring the findings among a sample of Ugandan parents (Skylstad et al., 2019), participants in this study also prescribed to the biomedical explanatory model by conceptualising mental health problems as a medical condition involving the dysfunction of the brain. Furthermore, participants in this study emphasised the role of emotions, describing mental health as a normal range of emotions, with the suppression of emotions causing mental health problems. However, this study’s participants did not prescribe to religious, indigenous, or spiritual causes of mental health problems as reported in another South African sample (Kometsi et al., 2020). It seems that participants in this study embrace several explanatory models for mental health problems, including psycho-social, emotional, and biomedical causes. The variety of explanatory models for mental health problems among this sample may have serious implications for research and clinical practice in the South African context. According to Furnham and Swami (2018), the communication between caregivers and mental healthcare professionals may be laboured when caregivers have difficulty communicating and recognising specific psychiatric labels or when mental healthcare professionals are not aware of their patients’ understanding of mental health problems. It will therefore benefit clinicians to be aware of the various explanatory models their patients prescribe to in order to ease communication, especially in the highly heterogenous cultural context of South Africa.

In addition to the beliefs about the causes of mental health problems participants shared as part of their conceptualisation of mental health, they also included the consequences of leaving mental health problems untreated. Participants emphasised that suppressing unpleasant emotions, i.e., not adequately addressing a mental health problem, may lead to undesirable consequences, including overwhelming emotions, difficulty in maintaining social relationship, and engaging in self-destructive behaviour. It has been shown that there is a strong relationship between mental health problems and other developmental and health concerns, including poor academic performance, interpersonal conflict, alcohol and drug abuse, aggressive behaviour, suicide, and transgressions of the law (Patel et al., 2007; Suldo et al., 2014). Although not technically a part of mental health literacy, as postulated by Jorm et al. (1997), participants showed great awareness of the consequences of untreated mental health problems as part of their conceptualisation of mental health. The awareness of consequences of untreated mental health problems may influence caregivers' motivation and intention to seek mental health support. Considering that mental health literacy interventions often aim to promote motivation and intention to seek help (Gulliver et al., 2012), it could benefit future researchers and clinicians to consider the consequences of untreated mental health in their understanding of mental health literacy and to incorporate it as a target for intervention.

Caregiver Availability

Participants in this study made use of several strategies to ensure their involvement in their children's lives, enabling them to recognise and support mental health problems (Hassett et al., 2018). Firstly, participants emphasised the importance of spending time with their children and taking an active interest in their activities. Similar to the findings of Honey et al. (2015), participants in this study felt that spending time with their children promotes a good caregiver-child relationship and communication, enabling them to recognise and address mental health problems should they arise. Secondly, participants provided emotional support to their children when experiencing emotional and mental health problems by encouraging them to talk about their feelings in an open and honest way, as well as by performing comforting gestures (reassurance, consoling and comfort, distraction, and religious practices). According to the theory by Hassett et al. (2018), these strategies contribute to caregivers' ability to be physically and emotionally available to their children. Consistent caregiver availability is crucial in caregivers' ability to recognise mental health problems, seeking help, and providing support to their children. However, there are multiple factors that may make it difficult for caregivers to be available to their children, consequently undermining the help-seeking process.

Wider Context

Participants in this study indicated that poverty was a major influence on their ability to meet their children's physical and mental health needs. Participants felt that it was their duty to meet their children's physical needs (for example food, shelter and schooling) as well emotional needs (love and care). However, participants expressed that they often lacked the financial means to provide children with physical support. If the physical and educational needs of children are left unmet, it may have consequences for their children's chances at a fulfilling life, increasing the risk of developing a mental health problem and contributing to an intergenerational cycle of poverty (Ward et al., 2015). Additionally, participants in this study often found it difficult to attend to their children and their children's emotional needs. Work and home responsibilities often left caregivers with little time to spend with their children. Similar to the findings of Honey et al. (2015), the burden of responsibilities is often exacerbated by family dynamics, such as single parent households, uninvolved partners, and marital issues. Consequently, barriers such as poverty and work and home responsibilities may both contribute towards the development of or the exacerbation of existing mental health problems in their children.

Participants in this study felt that they often had trouble protecting their children from external risk factors for developing mental health problems. Legal guardians (38.1% of the sample) found it difficult to manage the relationships between the child and their biological parents, which often resulted in children being exposed to physical and verbal abuse. The struggle to mitigate negative external influences often extended to the wider community, which constituted exposure to risk factors of mental health problems, including violence, inappropriate behaviour, and bullying. Indeed, South African children are exposed to high rates and multiple forms of victimisation (Dawes et al., 2005; Kaminer et al., 2013; Leoschut & Burton, 2006; Meinck et al., 2016). The lack of knowledge and support in dealing with such influences often lead participants to avoid mental health problems altogether. The avoidance of feelings of anger was especially salient among participants. Although avoidant coping is often considered to be a risk factor in the development of mental health problems in HIC (Pang & Thomas, 2020; Trickey et al., 2012), it can be an adaptive strategy in a context where safety is perpetually compromised. Indeed, a South African study by Hiller et al. (2017) indicated that in a high-risk context where there is a lack of security and ongoing reminders of events, avoidant behaviours among children and their caregivers (staying inside and avoiding conversations) may be adaptive, at least in the short term. Similar studies in high-risk communities in HIC have found that avoidant coping is associated with improved psychological outcomes for CYP, especially in contexts where they do not have control over their external environment (Gonzales et al., 2001; Griggs et al., 2019). However, a recent study has shown that avoidant coping may be associated with longer-term PTSD and complex features (Hiller et al., 2021). Consequently, caregivers' avoidance in dealing with external influences and the associated mental health problems among their children may be adaptive in the short term but may have long-term consequences for their mental health outcomes. Further research on the most helpful balance between physical safety and emotional health among South African CYP is necessary.

Participants felt they lacked the financial means to get mental health support for their children. Similar to other studies, the exorbitant costs of mental health services are often reported as a major barriers to accessing mental health services on behalf of their children (Hansen et al., 2021; Reardon et al., 2017). Even where mental health services are available in LMICs, like South Africa, these services are not affordable to many patients and their families (Sarikhani et al., 2020). Furthermore, limited and costly insurance coverage limits equitable access to mental health services (Sarikhani et al., 2020). Despite South Africa’s steps to strengthen public mental health care services, only 0.89% and 7.5% of uninsured South Africans (80% of total population) needing mental healthcare, received public inpatient and outpatient care, respectively (Docrat et al., 2019a; Maphumulo & Bhengu, 2019). The poor utilisation of public mental health services may be attributed to poor services provision caused by insufficient and incompetent human resources, imbalance in resource allocation, non-integrated services, and the low priority of mental health in health policy (Babatunde et al., 2020; Sarikhani et al., 2020). These barriers to mental health services may cause caregivers to experience a number of logistical issues, including long waiting list periods, traveling to available mental health services, complicated administrative systems, and a potential loss in wages (caregivers) and time spent in school (CYP) (Hansen et al., 2021; Reardon et al., 2020). The costs (monetary and time-related) associated with accessing mental health services leave many caregivers unable to access help for their children experiencing mental health problems.

Recognising Mental Health Problems

Participants in this study struggled to recognise mental health problems in their children. They reported that mental health problems could be recognised from certain behaviours presented by someone experiencing a mental health problem. Participants relied heavily on behaviours that they deemed socially unacceptable (for example fighting, obscene language, and abusing and manipulating others) to recognise mental health problems in others. Furthermore, participants also reported that a sudden change in behaviour (for example becoming quiet when usually talkative) is also indicative of mental health problems. These findings are consistent with other literature that indicates that caregivers find it easier to recognise mental health problems by behaviours that are not usually accepted in their social and cultural context or a sudden change in behaviour (Hurley et al., 2020; Lichtenberg et al., 2021; Skylstad et al., 2019). Although participants were able to recognise mental health problems from certain behaviours, they found it difficult to apply this knowledge to their children. Adolescence has been described as as period of transition from childhood to adulthood, often characterised by parental conflict, moodiness, and high-risk behaviours (Louw & Louw, 2014). It is possible that caregivers may find it difficult to distinguish between behaviours indicative of mental health problems and behaviours that are normal to this developmental phase. Indeed, several studies have shown that caregivers find it difficult to judge whether their children’s behaviours are “normal”, especially in context of adolescent behaviour (Reardon et al., 2017, 2020). Furthermore, participants in this study admitted that their children’s internal emotions and thoughts (i.e. internalising behaviours) were not as apparent and easily recognised as a problem. This finding is in line with that of Skylstad et al. (2019), where participants rarely described mental health problems in terms of emotions and thoughts. The difficulty the current study’s participants have to recognise emotions and thoughts may be further hindered by their children’s reluctance (or inability) to talk about their feelings and sharing their thoughts. Caregivers may, thus, find it easier to recognise mental health problems by observing externalising rather than internalising symptoms or behaviour (Hurley et al., 2020; Lichtenberg et al., 2021; Skylstad et al., 2019). Caregivers' difficulty in recognising emotional problems may cause internalising mental health problems, such as depression, anxiety, and PTSD, to go unnoticed among their children (Ogundele, 2018).

In this study, participants indicated that their own struggle with trauma and/or mental health problems hindered them from fulfilling their caregiver roles. Reardon et al. (2018) indicated that caregivers' own struggle with anxiety could potentially act either as a barrier or facilitator in further help-seeking for their children's mental health problems. Caregiver anxiety sometimes helped caregivers recognise similar symptoms in their own children, while other anxious caregivers were afraid of being overprotective or oversensitive, consequently not recognising symptoms in their children (Reardon et al., 2018). It seems as if the participants experienced their own struggles as a barrier to being emotionally available to their children. Participants expressed that they felt uncomfortable sharing their own feelings and struggles with their children, even if their children noticed an issue. In the theory by Hassett et al. (2018), this emotional unavailability on the part of the caregiver may discourage children from disclosing their mental health problem, thereby hindering caregiver involvement in the mental health help-seeking process. It is clear that caregivers required support for their own mental health problems to increase their emotional availability to their children.

Caregivers' Willingness to Engage with Support

Participants in this study often felt that the emotional and mental health problems they were experiencing at home did not warrant additional support from mental health services and professionals. Reardon et al. (2020) also showed caregivers' preference to deal with their children's problems at home as they believed the problem would improve without further support from mental health services. Hansen et al. (2021) also reported that caregivers often felt that their children's problems were not severe enough to engage with mental health services. According to Godoy et al. (2014), caregivers' appraisal of the symptoms of mental health problems among children is an important influencing factor in their intention to seek professional mental health support. Considering that the sample of this study also included caregivers who have not engaged with mental health services, it is fair to suggest that some individuals may indeed be confident in their appraisal and feel competent to deal with their children's emotional and mental health problems without the support of mental health professionals. However, caregivers may be demonstrating false confidence for several reasons. Firstly, as discussed above, caregivers may have difficulty recognising the severity of their children's emotional or mental health problem (Hansen et al., 2021; Reardon et al., 2017, 2020). A study by Wahlin and Deane (2012) suggest that caregivers may be unconcerned or unaware of the severity of their child's mental health problem. Even though caregivers may realise that a problem is present, the degree to which distress is expressed by the child may be assessed as low. This is especially true among children who do not feel comfortable confiding in their caregivers (Wahlin & Deane, 2012). Secondly, it is possible that caregivers may compare their child's troubles to a wider context of mental health among South African children. As stated before, South African children are disproportionately exposed to multiple risk factors for the development of mental health problems, including HIV/AIDS, poverty, and poly-victimisation (Kieling et al., 2011; Lund et al., 2011; Patel et al., 2010; Skeen et al., 2019). In the absence of such risk factors, caregivers may perceive their child's troubles as less severe relative to other children's experiences. However, further research is necessary to investigate this claim. Lastly, stigma may play an influential role in caregivers' willingness to access mental health support for their children. Although none of the participants in the current study expressed concern over stigma, stigma associated with mental health problems remains a major barrier to accessing mental health support among South Africans (Benjamin et al., 2021; Egbe et al., 2014; Strümpher et al., 2016). In parent/caregiver literature, several studies have reported on caregivers' fear of possible discrimination against their child if they were to engage with mental health services (Crouch et al., 2019; Hansen et al., 2021; Ofonedu et al., 2017; Ohan et al., 2015; Reardon et al., 2017). Furthermore, seeking mental health support for their child may make caregivers feel like they failed at raising and supporting their children (Hansen et al., 2021; Reardon et al., 2017, 2020). Stigma and self-stigmatisation may therefore motivate caregivers to solve mental health problems in the family context rather than seeking additional support from mental health professionals. Caregivers' willingness to engage with mental healthcare professionals may consequently be influenced by their difficulty to assess the severity of their children's mental health problem as well as their fear of stigmatisation.

Participants in this study, when describing mental health problems, would often refer to extreme cases of anxiety disorders, depression, bipolar disorder, schizophrenia, and psychotic behaviours. In contrast to the reluctance to engage with mental health services (as discussed above), participants expressed that such mental health problems, in fact, were serious and warranted attention and were treatable with medication and injections at medical facilities. It is unclear exactly where participants draw the line between mental health problems that warrant intervention and those that do not. Similar to the findings of Muga and Jenkins (2008) in Kenya, their public sample sought help from health services for psychological symptoms they perceived as being treatable by pharmacology, such as insomnia or aggressive psychotic behaviour. However, they were less likely to seek assistance from health services for mental health problems they believed required counselling (Muga & Jenkins, 2008). It is thus possible that the current study's participants also viewed the healthcare system as dispensers of medicine for medical conditions, rather than a source of support for mental health problems. Indeed, many participants described the cause of mental health problems, such as bipolar disorder and schizophrenia, as being biological in nature, i.e. physical illnesses. The selective help-seeking for mental health problems may be motivated by stigma surrounding help-seeking for mental health problems. Indeed, caregivers may find it more socially acceptable to seek help for problems they deem to have a medical cause, compared to those of a psychological nature (Benjamin et al., 2021). However, the severity of the mental health problems and the associated burden on the family may motivate caregivers to seek help, despite the possible stigmatisation. Indeed, studies have shown that familial burden (economic, social, and/or emotional strain caused by a child's mental health problem) is associated with an increased likelihood of engagement with CAMHS (Green et al., 2020; Ryan et al., 2015). Stigma and familial burden may thus be countering influences on where the line of acceptable mental health help-seeking lie.

Some participants in this study admitted to having trouble recognising mental health problems in their children and were often unsure how to appropriately respond to and support their child's issues. Indeed, many participants admitted to participating in this study in the hope of gaining knowledge on how to recognise and support mental health problems among their children. Similar to reports by Reardon et al. (2017, 2018, 2020), participants in this study were unaware of who to contact for help or what kind of resources are available for their child's mental health problem. Indeed, many of the participants were unaware of available mental health services at the school their children attend. This is interesting considering that there is an NGO that works in each of the target primary schools of this study and which provides free professional and individual psychological counselling to children, educators, and caregivers. Furthermore, interested clients can access these services through self-referral, so it is easily accessible. Even when participants were aware of the

NGO, they were unsure of what services they offered and the procedure to engage with these services. It would benefit future research to understand the communication between such mental health services and caregivers and to identify possible barriers.

Participants who felt ill-equipped or unknowledgeable in dealing with a mental health problem at home were often willing to seek support from their social networks (such as family members, friends, colleagues, and church leaders) but rarely mentioned relying on mental health services as an option. Like in Hurley et al. (2020), participants in this study found it acceptable to reach out to their social network for informal support. Caregivers benefit from this engagement as it provides emotional support and a safe space to talk and be heard (Honey et al., 2015). Feelings of incompetence in dealing with children's mental health problems might therefore be a predicting factor in caregivers' intent and behaviour in seeking mental health support (Reardon et al., 2018). Although participants were not against seeking help from mental health services, very few have had previous experiences and knowledge on how to engage with such services. Furthermore, when discussing the process of accessing mental health services, participants made little mention of any potential barriers and facilitators. These findings are in contrast with other studies where caregivers often reported on the role of systemic and logistical barriers to and facilitators in the help-seeking process (Ofonedu et al., 2017; Ohan et al., 2015; Reardon et al., 2017; Sarikhani et al., 2020). Looking at this lack of awareness of logistical issues in context of the help-seeking process, it could be that caregivers do not reach the step of intention where there is a plan of action to access mental healthcare and consider the possible barriers/facilitators that may affect that plan of action. It might be that caregivers, from the start, do not consider accessing mental healthcare as a viable option in the help-seeking process.

Some participants felt they lacked a support structure that valued trust and confidentiality, often fearing that others would break that trust, ultimately weaponising personal information against them. According to the theory set forth by Hassett et al. (2018), the lack of a supportive community involvement might be detrimental to CYP's help-seeking process. CYP who find themselves without trustworthy adults to whom they can disclose their mental health problem, often find themselves in a crisis situation, such as suicide attempts or psychosis, ultimately accessing mental healthcare via accident and emergency hospital units (Hassett et al., 2018). Indeed, participants in this study who had previous experiences with mental health services only engaged with such services because of external referrals and crisis situations.

Participants in this study who had engaged with mental health services for their children reported having good experiences. Comparable to the findings in Hurley et al. (2020) and Reardon et al. (2017), participants came to value the therapeutic alliance between them and the mental healthcare professionals. Participants in this study valued being an active agent in the therapeutic process and having open and honest conversations with the mental healthcare professional. A good therapeutic relationship has been shown to be instrumental to the help-seeking process since it leads to higher satisfaction with care and willingness to engage with mental healthcare services on behalf of their children (Butler et al., 2015; Hassett et al., 2018; Hurley et al., 2020). Furthermore, caregivers who have had good experiences with engaging with mental health services may be able to provide encouragement, support, and advice to others who are in similar situations (Crouch et al., 2019; Honey et al., 2015; Hurley et al., 2021). Participants in this study emphasised the benefits of engaging with mental health services as it offered them knowledge and support in correcting parenting styles, recognising problems their children are experiencing, insight into the motivations behind their child's actions, building a relationship with their child, and how to be supportive of their child who is engaged in therapy. According to the theory proposed by Hassett et al. (2018), the expertise of mental healthcare professionals are essential in not only addressing the mental health problem, but continuing the caregivers' and child's engagement with the therapeutic process and moving towards a place where CYP can independently seek support without relying on their caregivers.

Strengths and Limitations

The current study had two main strengths. Firstly, this study is the first to explore caregivers' perceptions of their involvement in their children's MH and MHS in the South African context. This study provides an initial understanding of how caregivers conceptualise mental health, the role they play in their children's mental health help-seeking process and the possible barriers and facilitators they experience in fulfilling this role. Secondly, data were collected from an extensive sample recruited from multiple sites in the Stellenbosch area. Although these findings cannot be generalised to the South African population as a whole, it might be transferable to other similar contexts.

The current study also had three main limitations. Firstly, only caregivers of CYP were recruited for this study, which limits the understanding of the complex relationship between caregiver and child to the perspective of the caregiver. Future research might benefit from including the perspectives of both CYP and CAMH professionals to gain a broader and more in-depth understanding of the role of caregivers in their children's MH and MHS. Secondly, the participants included in this study might not be entirely representative of the population from which they were recruited. There might be inherent differences between caregivers who were willing to participate and those who were not. Furthermore, due to logistical reasons, working caregivers and/or hard to reach caregivers could not be included in this study. Thirdly, the data were collected before COVID-19 restrictions and rules were implemented. As we have seen, the pandemic has had an immense impact on the mental wellbeing of individuals globally. Consequently, the pandemic and associated restrictions might have changed caregivers' perceptions of their role in their children's MH and MHS. However, the current context of COVID-19 and mental health has highlighted the need for appropriate and effective caregiver intervention to support them in their role.

Conclusion

In this research study I sought to explore caregivers' perceptions of their role in their children's MH and MHS, focusing on caregivers' conceptualisation of mental health, how they deal with mental health problems in the family context, how they perceive their involvement in their children's MH and MHS, and the barriers and facilitators they perceived in this involvement.

Although participants in this study struggled to articulate their understanding of mental health, they made use of various explanatory models (psycho-social, emotional, and biomedical) to explain the causes of mental health problems and showed great awareness of the consequences of leaving mental health problems untreated. Participants displayed a variety of strategies to ensure their emotional availability to their children in order to recognise and deal with their children's mental health problems. These strategies often centred around building a positive caregiver-child relationship by spending time with children, encouraging open and honest conversation, and providing emotional support. However, participants also experienced multiple barriers in their ability to be emotionally available and involved in their child's MH and MHS.

Firstly, wider contextual factors, such as poverty, home and work responsibilities, family dynamics, and their children's exposure to multiple forms of victimisation often left caregivers unable to be emotionally available, supportive, and to access appropriate support for their child's mental health problems. Participants' lack of knowledge and resources to address these issues often caused caregivers to avoid the issues altogether. Although avoidance coping might be considered adaptive in a high-risk setting such as South Africa, the long-term effects are uncertain. Secondly, participants in this study struggled to recognise mental health problems in their children. Although participants reported being able to recognise mental health problems in others from unusual behaviours or sudden changes in behaviours, they found it difficult to apply this understanding to their children, often finding it difficult to distinguish between problematic behaviour and “normal” adolescent behaviour. Participants also struggled to identify worrisome emotions and thoughts, which is often further complicated by their children’s reluctance to disclose. Furthermore, participants’ own struggles with mental health problems and reluctance to talk to their children about it often hindered caregiver involvement and may have implications for children’s willingness to disclose their mental health problems. Thirdly, participants felt their children’s mental health problems were not serious enough to warrant intervention from CAMHS, which could potentially be explained by caregivers’ difficulty in appraising the severity of their children’s mental health problem or fear of stigmatisation. Participants who were able to recognise their children’s mental health problems and the need for further intervention, did not know where or how to seek for help from CAMHS. Participants found it acceptable to reach out to their social network for support and advice but were often concerned about trust and confidentiality. Participants who did have experiences with CAMHS, often through referrals and crisis situations, reported positive experiences and emphasised the importance of the therapeutic relationship and valued the knowledge and support they received from CAMH professionals.

These findings highlight the complexities of caregiver involvement in CAMH and services. The findings also show that caregivers require support to understand mental health problems in their children, to overcome the burden of wider contextual factors, to recognise mental health problems, and to navigate the help-seeking process. Supporting caregivers on these fronts will help promote their emotional availability to their children and their involvement in their children’s mental health and to appropriately respond to mental health problems that might arise. The impact of COVID-19 on caregiver and CYP mental health further necessitates research on the subject and the development of appropriate interventions.

References

Abrahams, Z., Boisits, S., Schneider, M., Prince, M., & Lund, C. (2020). Domestic violence , food insecurity and mental health of pregnant women in the COVID-19 lockdown in Cape Town , South Africa. *Research Square*. https://doi.org/10.21203/rs.3.rs-102205/v1

Ajzen, I. (1991). The theory of planned behavior. *Organizational Behavior and Human Decision Processes*, *50*(2), 179–211. https://doi.org/10.1016/0749-5978(91)90020-T

Alem, A., Kebede, D., Fekadu, A., Shibre, T., Fekadu, D., Beyero, T., Medhin, G., Negash, A., & Kullgren, G. (2009). Clinical course and outcome of Schizophrenia in a predominantly treatment-naive cohort in rural ethiopia. *Schizophrenia Bulletin*, *35*(3), 646–654. https://doi.org/10.1093/schbul/sbn029

American Psychiatric Association. (2002). *Practice Guidelines for Treatment of Patients with Bipolar Disorder* (2nd ed.). American Psychiatric Association Press.

American Psychiatric Association. (2010a). *Practice Guidelines for Treatment of Patients with Major Depressive Disorder* (3rd ed.). American Psychiatric Association.

American Psychiatric Association. (2010b). *Practice Guidelines for Treatment of Patients with Panic Disorder* (2nd ed.). American Psychiatric Association Press.

Andersen, L., Kagee, A., O’Cleirigh, C., Safren, S., & Joska, J. (2015). Understanding the experience and manifestation of depression in people living with HIV/AIDS in South Africa. *AIDS Care*, *27*(1), 59–62. https://doi.org/10.1080/09540121.2014.951306

Andrade, L. H., Alonso, J., Mneimneh, Z., Wells, J. E., Al-Hamzawi, A., Borges, G., Bromet, E., Bruffaerts, R., de Girolamo, G., de Graaf, R., Florescu, S., Gureje, O., Hinkov, H. R., Hu, C., Huang, Y., Hwang, I., Jin, R., Karam, E. G., Kovess-Masfety, V., … Kessler, R. C. (2014). Barriers to mental health treatment: results from the WHO World Mental Health surveys. *Psychological Medicine*, *44*(6), 1303–1317. https://doi.org/10.1017/S0033291713001943

Antwi, S. K., & Kasim, H. (2015). Qualitative and Quantitative Research Paradigms in Business Research. *A Philosophical Reflection*, *7*(3), 217–225. https://www.researchgate.net/publication/295087782

Anyan, F. (2015). The Influence of Power Shifts in Data Collection and Analysis Stages : A Focus on Qualitative Research Interview. *The Qualitative Report*.

https://doi.org/10.46743/2160-3715/2013.1525

Arseniou, S., Arvaniti, A., & Samakouri, M. (2014). HIV infection and depression. *Psychiatry and Clinical Neurosciences*, *68*(2), 96–109. https://doi.org/10.1111/pcn.12097

Artz, L., Burton, P., Ward, C. L., Leoschut, L., Phyfer, J., Loyd, S., & Le Mottee, C. (2016). *Sexual victimisation of children in South Africa: Final report of the Otimus FOundation Study*. http://www.cjcp.org.za/uploads/2/7/8/4/27845461/cjcp_ubs_web.pdf

Babatunde, G. B., van Rensburg, A. J., Bhana, A., & Petersen, I. (2020). Stakeholders' perceptions of child and adolescent mental health services in a South African district: a qualitative study. *International Journal of Mental Health Systems*, *14*(1), 73. https://doi.org/10.1186/s13033-020-00406-2

Backe, E. L., Bosire, E. N., Kim, A. W., & Mendenhall, E. (2021). "Thinking Too Much": A Systematic Review of the Idiom of Distress in Sub-Saharan Africa. *Culture, Medicine, and Psychiatry*. https://doi.org/10.1007/s11013-020-09697-z

Baranne, M. L., & Falissard, B. (2018). Global burden of mental disorders among children aged 5–14 years. *Child and Adolescent Psychiatry and Mental Health*, *12*(1), 19. https://doi.org/10.1186/s13034-018-0225-4

Barry, M. M., Clarke, A. M., Jenkins, R., & Patel, V. (2013). A systematic review of the effectiveness of mental health promotion interventions for young people in low and middle income countries. *BMC Public Health*, *13*(1), 835. https://doi.org/10.1186/1471-2458-13-835

Baumrind, D. (1971). Current patterns of parental authority. *Developmental Psychology*, *4*(1, Pt.2), 1–103. https://doi.org/10.1037/h0030372

Belfer, M. L. (2008). Child and adolescent mental disorders: the magnitude of the problem across the globe. *Journal of Child Psychology and Psychiatry*, *49*(3), 226–236. https://doi.org/10.1111/j.1469-7610.2007.01855.x

Benjamin, F., Vickerman-Delport, S. A., & Roman, N. V. (2021). Mental health care services in rural South Africa: a human capabilities approach. *Social Work in Mental Health*, *19*(5), 365–380. https://doi.org/10.1080/15332985.2021.1927283

Bhana, A., Mellins, C. A., Petersen, I., Alicea, S., Myeza, N., Holst, H., Abrams, E., John, S., Chhagan, M., Nestadt, D. F., Leu, C.-S., & McKay, M. (2014). The VUKA family program: Piloting a family-based psychosocial intervention to promote health and mental health among HIV infected early adolescents in South Africa. *AIDS Care*, *26*(1), 1–11. https://doi.org/10.1080/09540121.2013.806770

Bless, C., Higson-Smith, C., & Sithole, L. (2013). *Fundamentals of social research methods: An African perspective* (C. Bless, C. Higson-Smith, & L. Sithole (eds.); 5th ed.). Juta Books.

Boulter, E., & Rickwood, D. (2013). Parents' experience of seeking help for children with mental health problems. *Advances in Mental Health*, *11*(2), 131–142. https://doi.org/10.5172/jamh.2013.11.2.131

Boyes, M. E., Cluver, L. D., Meinck, F., Casale, M., & Newnham, E. (2019). Mental health in South African adolescents living with HIV: correlates of internalising and externalising symptoms. *AIDS Care - Psychological and Socio-Medical Aspects of AIDS/HIV*, *31*(1), 95–104. https://doi.org/10.1080/09540121.2018.1524121

Bradshaw, M., Gericke, H., Coetzee, B. J., Stallard, P., Human, S., & Loades, M. (2020). Universal school-based mental health programmes in low- and middle-income countries: A systematic review and narrative synthesis. *Preventive Medicine*, *143*(May 2020), 106317. https://doi.org/10.1016/j.ypmed.2020.106317

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77–101.

Bryman, A. (2012). *Social research methods* (A. Bryman (ed.); 4th ed.). Oxford University Press.

Burke, J. D., Pardini, D. A., & Loeber, R. (2008). Reciprocal Relationships Between Parenting Behavior and Disruptive Psychopathology from Childhood Through Adolescence. *Journal of Abnormal Child Psychology*, *36*(5), 679–692. https://doi.org/10.1007/s10802-008-9219-7

Burn, M., Lewis, A., Mcdonald, L., & Toumbourou, J. W. (2019). An Australian adaptation of the Strengthening Families Program: Parent and child mental health outcomes from a pilot study. *Australian Psychologist*, *54*(4), 261–271. https://doi.org/10.1111/ap.12385

Butler, A. M., Weller, B., & Titus, C. (2015). Relationships of Shared Decision Making with

Parental Perceptions of Child Mental Health Functioning and Care. *Administration and Policy in Mental Health and Mental Health Services Research*, *42*(6), 767–774. https://doi.org/10.1007/s10488-014-0612-y

Campbell-Hall, V., Petersen, I., Bhana, A., Mjadu, S., Hosegood, V., & Flisher, A. J. (2010). Collaboration Between Traditional Practitioners and Primary Health Care Staff in South Africa: DevelopinG a Workable Partnership for Community Mental Health Services. *Transcultural Psychiatry*, *47*(4), 610–628. https://doi.org/10.1177/1363461510383459

Cluver, L. D., Meinck, F., Steinert, J. I., Shenderovich, Y., Doubt, J., Herrero Romero, R., Lombard, C. J., Redfern, A., Ward, C. L., Tsoanyane, S., Nzima, D., Sibanda, N., Wittesaele, C., De Stone, S., Boyes, M. E., Catanho, R., Lachman, J. M., Salah, N., Nocuza, M., & Gardner, F. (2018). Parenting for Lifelong Health: a pragmatic cluster randomised controlled trial of a non-commercialised parenting programme for adolescents and their families in South Africa. *BMJ Global Health*, *3*(1), e000539. https://doi.org/10.1136/bmjgh-2017-000539

Cluver, L. D., Orkin, M., Gardner, F., & Boyes, M. E. (2012). Persisting mental health problems among AIDS-orphaned children in South Africa. *Journal of Child Psychology and Psychiatry and Allied Disciplines*, *53*(4), 363–370. https://doi.org/10.1111/j.1469-7610.2011.02459.x

Cluver, L., Meinck, F., Yakubovich, A., Doubt, J., Redfern, A., Ward, C., Salah, N., De Stone, S., Petersen, T., Mpimpilashe, P., Romero, R. H., Ncobo, L., Lachman, J., Tsoanyane, S., Shenderovich, Y., Loening, H., Byrne, J., Sherr, L., Kaplan, L., & Gardner, F. (2016). Reducing child abuse amongst adolescents in low- and middle-income countries: A pre-post trial in South Africa. *BMC Public Health*, *16*(1), 567. https://doi.org/10.1186/s12889-016-3262-z

Coetzee, B., Gericke, H., Human, S., Stallard, P., & Loades, M. (2021). How young people experienced COVID-19 disease containment measures in the Western Cape, South Africa: A qualitative study including the perspectives of young people, their parents, teachers and school counsellors. *Psychology and Psychotherapy: Theory, Research and Practice*, *February*, 1–19. https://doi.org/10.1111/papt.12374

Coetzee, B. J., Gericke, H., Human, S., Stallard, P., & Loades, M. (2021). What should a Universal School-Based Psychoeducational Programme to Support Psychological Well-

Being amongst Children and Young People in South Africa Focus on and how should it be Delivered? A Multi-Stakeholder Perspective. *School Mental Health*, *0123456789*. https://doi.org/10.1007/s12310-021-09465-3

Collins, C. S., & Stockton, C. M. (2018). The Central Role of Theory in Qualitative Research. *International Journal of Qualitative Methods*, *17*(1), 1–10. https://doi.org/10.1177/1609406918797475

Collishaw, S., Gardner, F., Lawrence Aber, J., & Cluver, L. (2016). Predictors of Mental Health Resilience in Children who Have Been Parentally Bereaved by AIDS in Urban South Africa. *Journal of Abnormal Child Psychology*, *44*(4), 719–730. https://doi.org/10.1007/s10802-015-0068-x

Costello, E. J., Mustillo, S., Erkanli, A., Keeler, G., & Angold, A. (2003). Prevalence and development of psychiatric disorders in childhood and adolescence. *Arch Gen Psychiatry*, *60*(8), 837–844.

Crouch, L., Reardon, T., Farrington, A., Glover, F., & Creswell, C. (2019). “Just keep pushing”: Parents’ experiences of accessing child and adolescent mental health services for child anxiety problems. *Child: Care, Health and Development*, *45*(4), 491–499. https://doi.org/10.1111/cch.12672

Dang, H. M., Phan, R., Weiss, B., Dang, T., Pollack, A., Tran, N., & Nguyen, M. L. (2021). Child Mental Health Literacy Among Vietnamese and Cambodian Mothers. *Psychological Studies*, *66*(1), 62–72. https://doi.org/10.1007/s12646-020-00590-8

Dawes, A., Lund, C., Kafaar, Z., Brandt, R., & Flisher, A. J. (2004). *Norms for South African child and adolescent mental health services (CAMHS). Report for the Directorate: Mental Health and Substance Abuse, National DoH (Department of Health)*.

Dawes, A., Robertson, B., Duncan, N., Ensink, K., Jackson, A., Reynolds, P., Pillay, A., & Richter, L. (1997). Child and Adolescent Mental Health Policy. In D. Foster, M. Freeman, & Y. Pillay (Eds.), *Mental Health Policy Issues for South Africa* (pp. 193–215). Medical ASsociation of South Africa Multimedia Publications.

Dawes, Andrew. (2009). The South African children’s act. *Journal of Child and Adolescent Mental Health*, *21*(2). https://doi.org/10.2989/JCAMH.2009.21.2.1.1009

Dawes, E., De Sas Kropiwnicki, Z., Kafaar, Z., & Richter, L. (2005). Survey examines South

Africa’s attitude towards corporal punishment. *Article*.

Department of Health. (1997). *White Paper for the Transformation of the Health System in South Africa*. Department of Health.

Department of Health. (2004). *MENTAL HEALTH CARE ACT 17 OF 2002*. http://www.justice.gov.za/legislation/acts/2002-017_mentalhealthcare.pdf

Department of Health. (2014). *National Mental Health Policy Framework and Strategic Plan*. https://doi.org/10.1111/1440-1630.12231

Desai, G., & Chaturvedi, S. K. (2017). Idioms of Distress. *Journal of Neuroscience in Rural Practice*, *8*. https://doi.org/10.4103/jnrp.jnrp

Devereux, S., Hochfield, T., Karriem, A., Mensah, C., Morahanye, M., Msimango, T., Mukubonda, A., Naicker, S., Nkomo, G., Sanders, D., & Sanousi, M. (2018). *School feeding in South Africa: What we know, what we don’t know, what we need to know, what we need to do.* (No. 004; Food Security SA Working Paper Series). https://foodsecurity.ac.za/wp-content/uploads/2018/06/CoE-FS-WP4-School-Feeding-in-South-Africa-11-jun-18.pdf

Docrat, S., Besada, D., Cleary, S., Daviaud, E., & Lund, C. (2019a). Mental health system costs, resources and constraints in South Africa: A national survey. *Health Policy and Planning*, *34*(9), 706–719. https://doi.org/10.1093/heapol/czz085

Docrat, S., Besada, D., Cleary, S., Daviaud, E., & Lund, C. (2019b). Mental health system costs, resources and constraints in South Africa: a national survey. *Health Policy and Planning*, *34*(9), 706–719. https://doi.org/10.1093/heapol/czz085

Draper, C. E., Lund, C., Kleintjies, S., Funk, M., Omar, M., & Flisher, A. J. (2009). Mental health policy in South Africa: Development process and content. *Health Policy and Planning*, *24*, 342–356. https://doi.org/10.1177/097206341001300111

Egbe, C. O., Brooke-Sumner, C., Kathree, T., Selohilwe, O., Thornicroft, G., & Petersen, I. (2014). Psychiatric stigma and discrimination in South Africa: Perspectives from key stakeholders. *BMC Psychiatry*, *14*(1), 1–14. https://doi.org/10.1186/1471-244X-14-191

Eloff, I., Finestone, M., Makin, J. D., Boeving-Allen, A., Visser, M., Ebersöhn, L., Ferreira, R., Sikkema, K. J., Briggs-Gowan, M. J., & Forsyth, B. W. C. (2014). A randomized clinical trial of an intervention to promote resilience in young children of HIV-positive mothers in South Africa. *AIDS*, *28*(Supplement 3), S347–S357. https://doi.org/10.1097/QAD.0000000000000335

Erskine, H. E., Baxter, A. J., Patton, G., Moffitt, T. E., Patel, V., Whiteford, H. A., & Scott, J. G. (2017). The global coverage of prevalence data for mental disorders in children and adolescents. *Epidemiology and Psychiatric Sciences*, *26*(4), 395–402. https://doi.org/10.1017/S2045796015001158

Essau, C. A. (2005). Frequency and patterns of mental health services utilization among adolescents with anxiety and depressive disorders. *Depression and Anxiety*, *22*(3), 130–137. https://doi.org/10.1002/da.20115

Fazel, M., Patel, V., Thomas, S., & Tol, W. (2014). Mental health interventions in schools in low-income and middle-income countries. *The Lancet Psychiatry*, *1*(5), 388–398. https://doi.org/10.1016/S2215-0366(14)70357-8

Flisher, A. J., Dawes, A., Kafaar, Z., Lund, C., Sorsdahl, K., Myers, B., Thom, R., & Seedat, S. (2012). Child and adolescent mental health in South Africa. *Journal of Child & Adolescent Mental Health*, *24*(2), 149–161. https://doi.org/10.2989/17280583.2012.735505

Furnham, A., & Swami, V. (2018). Mental Health Literacy: A Review of What it is and Why it Matters. *International Perspectives in Psychology: Research, Practice, Consultation*, *7*(4), 240–257. https://doi.org/110.1037/ipp0000094

Fusch, P. I., & Ness, L. R. (2015). Are we there yet? Saturation in qualitative research. *The Qualitative Report*, *20*(9), 1408–1416. https://nsuworks.nova.edu/tqr/vol20/iss9/3

Ganasen, K. A., Parker, S., Hugo, C. J., Stein, D. J., Emsley, R. A., & Seedat, S. (2008). Mental health literacy: Focus on developing countries. *African Journal of Psychiatry (South Africa)*, *11*(1), 23–28. https://doi.org/10.4314/ajpsy.v11i1.30251

Gearing, R. E. (2004). Bracketing in Research : A Typology. *Qualitative Health Research*, *14*(10), 1429–1452. https://doi.org/10.1177/1049732304270394

Gittings, L., Toska, E., Medley, S., Cluver, L., Logie, C. H., Ralayo, N., Chen, J., & Mbithi-Dikgole, J. (2021). ‘Now my life is stuck!’: Experiences of adolescents and young people during COVID-19 lockdown in South Africa. *Global Public Health*, *16*(6), 947–963. https://doi.org/10.1080/17441692.2021.1899262

Godoy, L., Mian, N. D., Eisenhower, A. S., & Carter, A. S. (2014). Pathways to service receipt: Modeling parent help-seeking for childhood mental health problems. *Administration and Policy in Mental Health and Mental Health Services Research*, *41*(4), 469–479. https://doi.org/10.1007/s10488-013-0484-6

Gondek, D., Edbrooke-Childs, J., Velikonja, T., Chapman, L., Saunders, F., Hayes, D., & Wolpert, M. (2017). Facilitators and Barriers to Person-centred Care in Child and Young People Mental Health Services: A Systematic Review. *Clinical Psychology and Psychotherapy*, *24*(4), 870–886. https://doi.org/10.1002/cpp.2052

Gonzales, N. A., Tein, J.-Y., Sandler, I. N., & Friedman, R. J. (2001). On the Limits of Coping. *Journal of Adolescent Research*, *16*(4), 372–395. https://doi.org/10.1177/0743558401164005

Graham, A., Hasking, P., Brooker, J., Clarke, D., & Meadows, G. (2017). Mental health service use among those with depression: an exploration using Andersen’s Behavioral Model of Health Service Use. *Journal of Affective Disorders*, *208*, 170–176. https://doi.org/10.1016/j.jad.2016.08.074

Green, A. L., Kutash, K., Ferron, J., Levin, B. L., Debate, R., & Baldwin, J. (2020). Understanding Caregiver Strain and Related Constructs in Caregivers of Youth with Emotional and Behavioral Disorders. *Journal of Child and Family Studies*, *29*(3), 761–772. https://doi.org/10.1007/s10826-019-01626-y

Griggs, S., Ratner, H. H., Hannigan, J. H., Delaney-Black, V., & Chiodo, L. M. (2019). Violence exposure, conflict, and health outcomes in inner-city African American adolescents. *Nursing Forum*, *54*(4), 513–525. https://doi.org/10.1111/nuf.12365

Grill, H. (2019). What Women Want: A Discussion of “Childless.” *Psychoanalytic Dialogues*, *29*(1), 59–68. https://doi.org/10.1080/10481885.2018.1560867

Guba, E. G. (1981). ERIC/ECTJ Annual Review Paper: Criteria for Assessing the Trustworthiness of Naturalistic Inquiries. *Educational Communication and Technology*, *29*(2), 75–91. http://www.jstor.org/stable/30219811

Guba, E. G. (1985). The context of emergent paradigm research. In Y. S. Lincoln (Ed.), *Organization theory and inquiry: the paradigm revolution*. SAGE.

Guba, E. G., & Lincoln, Y. S. (1994). Competing Paradigms in Qualitative Research. In N.

K. Denzin & Y. S. Lincoln (Eds.). *Handbook of Qualitative Research*, 105–117.

Gulliver, A., Griffiths, K. M., & Christensen, H. (2010). Perceived barriers and facilitators to mental health help-seeking in young people: a systematic review. *BMC Psychiatry*, *10*(1), 113. https://doi.org/10.1186/1471-244X-10-113

Gulliver, A., Griffiths, K. M., Christensen, H., & Brewer, J. L. (2012). A systematic review of help-seeking interventions for depression, anxiety and general psychological distress. *BMC Psychiatry*, *12*(1), 81. https://doi.org/10.1186/1471-244X-12-81

Haine-Schlagel, R., & Walsh, N. E. (2015). A Review of Parent Participation Engagement in Child and Family Mental Health Treatment. *Clinical Child and Family Psychology Review*, *18*(2), 133–150. https://doi.org/10.1007/s10567-015-0182-x

Hall, K., & Mokomane, Z. (2018). The shape of children's families and households: A demographic overview. In K. Hall, L. Richter, Z. Mokomane, & L. Lake (Eds.), *South African Child Gauge: Children, Families and the State* (pp. 32–45). Cape Town: Children's Institute, University of Cape Town. http://www.ci.uct.ac.za/ci/child-gauge/2018

Hansen, A. S., Telléus, G. K., Mohr-Jensen, C., & Lauritsen, M. B. (2021). Parent-perceived barriers to accessing services for their child's mental health problems. *Child and Adolescent Psychiatry and Mental Health*, *15*(1), 4. https://doi.org/10.1186/s13034-021-00357-7

Hassett, A., Green, C., & Zundel, T. (2018). Parental Involvement: A Grounded Theory of the Role of Parents in Adolescent Help Seeking for Mental Health Problems. *SAGE Open*, *8*(4). https://doi.org/10.1177/2158244018807786

Herman, A. A., Stein, D. J., Seedat, S., Heeringa, S. G., Moomal, H., & Williams, D. R. (2009). The South African Stress and Health (SASH) study: 12-month and lifetime prevalence of common mental disorders. *South African Medical Journal*, *99*(5).

Hiller, R. M., Halligan, S. L., Tomlinson, M., Stewart, J., Skeen, S., & Christie, H. (2017). Post-trauma coping in the context of significant adversity: A qualitative study of young people living in an urban township in South Africa. *BMJ Open*, *7*(10), 1–10. https://doi.org/10.1136/bmjopen-2017-016560

Hiller, R. M., Meiser-Stedman, R., Elliott, E., Banting, R., & Halligan, S. L. (2021). A longitudinal study of cognitive predictors of (complex) post-traumatic stress in young people in out-of-home care. *Journal of Child Psychology and Psychiatry and Allied Disciplines*, *62*(1), 48–57. https://doi.org/10.1111/jcpp.13232

Honey, A., Chesterman, S., Hancock, N., Llewellyn, G., Hazell, P., & Clarke, S. (2015). Knowing What to Do and Being Able to Do It: Influences on Parent Choice and Use of Practices to Support Young People Living with Mental Illness. *Community Mental Health Journal*, *51*(7), 841–851. https://doi.org/10.1007/s10597-015-9864-6

Hooblaul, M., Cobbing, S., & Daniels, K. J. (2020). The knowledge, attitudes and perceptions of physiotherapists in KwaZulu-Natal, South Africa, towards mental health. *South African Journal of Physiotherapy*, *76*(1), 1–7. https://doi.org/10.4102/sajp.v76i1.1483

Horn, L., Graham, C., Prozesky, H., & Theron, C. (2015). *Getting Ethics Approval for Your Research Project* (L. Horn, C. Graham, H. Prozesky, & C. Theron (eds.); 1st ed.). Research Ethics Committee: Humanities.

Hugo, C. J., Boshoff, D. E. L., Traut, A., Zungu-Dirwayi, N., & Stein, D. J. (2003). Community attitudes toward and knowledge of mental illness in South Africa. *Social Psychiatry and Psychiatric Epidemiology*, *38*(12), 715–719. https://doi.org/10.1007/s00127-003-0695-3

Humm, A., Kaminer, D., & Hardy, A. (2018). Social support, violence exposure and mental health among young South African adolescents. *Journal of Child & Adolescent Mental Health*, *30*(1), 41–50. https://doi.org/10.2989/17280583.2018.1476358

Hurley, D., Allen, M. S., Swann, C., & Vella, S. A. (2021). A Matched Control Trial of a Mental Health Literacy Intervention for Parents in Community Sports Clubs. *Child Psychiatry & Human Development*, *52*(1), 141–153. https://doi.org/10.1007/s10578-020-00998-3

Hurley, D., Swann, C., Allen, M. S., Ferguson, H. L., & Vella, S. A. (2020). A Systematic Review of Parent and Caregiver Mental Health Literacy. *Community Mental Health Journal*, *56*(1), 2–21. https://doi.org/10.1007/s10597-019-00454-0

Jack, H. E., Myers, B., Regenauer, K. S., & Magidson, J. F. (2020). Mutual Capacity Building to Reduce the Behavioral Health Treatment Gap Globally. *Administration and Policy in Mental Health and Mental Health Services Research*, *47*(4), 497–500.

https://doi.org/10.1007/s10488-019-00999-y

Johnco, C., Salloum, A., McBride, N. M., Cepeda, S. L., Guttfreund, D., Novoa, J. C., & Storch, E. A. (2019). Mental health literacy, treatment preferences, and barriers in Salvadorian parents. *International Journal of Mental Health*, *48*(3), 139–164. https://doi.org/10.1080/00207411.2019.1629376

Jorm, A. F. (2012). Mental health literacy; empowering the community to take action for better mental health. *American Psychologist*, *67*(3), 231–243. https://doi.org/10.1037/a0025957

Jorm, A. F., Korten, A. E., Jacomb, P. A., Christensen, H., Rodgers, B., & Pollitt, P. (1997). "Mental health literacy": a survey of the public's ability to recognise mental disorders and their beliefs about the effectiveness of treatment. *Medical Journal of Australia*, *166*(4), 182–186. https://doi.org/10.5694/j.1326-5377.1997.tb140071.x

Jorm, A. F., Patten, S. B., Brugha, T. S., & Mojtabai, R. (2017). Has increased provision of treatment reduced the prevalence of common mental disorders? Review of the evidence from four countries. *World Psychiatry*, *16*(1), 90–99. https://doi.org/10.1002/wps.20388

Kaminer, D., du Plessis, B., Hardy, A., & Benjamin, A. (2013). Exposure to violence across multiple sites among young South African adolescents. *Peace and Conflict: Journal of Peace Psychology*, *19*(2), 112–124. https://doi.org/10.1037/a0032487

Karnieli-Miller, O., Strier, R., & Pessach, L. (2009). Power Relations in Qualitative Research. *Qualitative Health Research*, *19*(2), 279–289. https://doi.org/10.1177/1049732308329306

Kern, L., Mathur, S. R., Albrecht, S. F., Poland, S., Rozalski, M., & Skiba, R. J. (2017). The Need for School-Based Mental Health Services and Recommendations for Implementation. *School Mental Health*, *9*, 205–217. https://doi.org/10.1007/s12310-017-9216-5

Kessler, R. C., Amminger, G. P., Aguilar-Gaxiola, S., Alonso, J., Lee, S., & Üstün, T. B. (2007). Age of onset of mental disorders: A review of recent literature. *Current Opinion in Psychiatry*, *20*(4), 359–364. https://doi.org/10.1097/YCO.0b013e32816ebc8c

Kessler, R. C., Berglund, P., Demler, O., Jin, R., Merikangas, K. R., & Walters, E. E. (2005). Lifetime Prevalence and Age-of-Onset Distributions of DSM-IV Disorders in the

National Comorbidity Survey Replication. *Arch Gen Psychiatry*, *62*, 593–602.

Kieling, C., Baker-Henningham, H., Belfer, M., Conti, G., Ertem, I., Omigbodun, O., Rohde, L. A., Srinath, S., Ulkuer, N., & Rahman, A. (2011). Child and adolescent mental health worldwide: Evidence for action. *The Lancet*, *378*(9801), 1515–1525. https://doi.org/10.1016/S0140-6736(11)60827-1

Kinyanda, E., Levin, J., Nakasujja, N., Birabwa, H., Nakku, J., Mpango, R., Grosskurth, H., Seedat, S., Araya, R., Shahmanesh, M., & Patel, V. (2018). Major Depressive Disorder: Longitudinal Analysis of Impact on Clinical and Behavioral Outcomes in Uganda. *JAIDS Journal of Acquired Immune Deficiency Syndromes*, *78*(2), 136–143. https://doi.org/10.1097/QAI.0000000000001647

Kivunja, C., & Kuyini, A. B. (2017). Understanding and Applying Research Paradigms in Educational Contexts. *International Journal of Higher Education*, *6*(5), 26. https://doi.org/10.5430/ijhe.v6n5p26

Kleintjes, S., Flisher, A., Fick, M., Railoun, A., Lund, C., Molteno, C., & Robertson, B. (2006). The prevalence of mental disorders among children, adolescents and adults in the Western Cape, South Africa. *African Journal of Psychiatry*, *9*(3), 157–160. https://doi.org/10.4314/ajpsy.v9i3.30217

Kleintjes, S., Lund, C., & Flisher, A. J. (2010). A situational analysis of child and adolescent mental health services in Ghana, Uganda, South Africa and Zambia. *African Journal of Psychiatry (South Africa)*, *13*(2), 132–139. https://doi.org/10.4314/ajpsy.v13i2.54360

Kohn, R., Saxena, S., Levav, I., & Saraceno, B. (2004). The treatment gap in mental health care. *Bulletin of the World Health Organization*, *82*(11), 858–866. https://doi.org//S0042-96862004001100011

Kometsi, M. J., Mkhize, N. J., & Pillay, A. L. (2020). Mental health literacy: conceptions of mental illness among African residents of Sisonke District in KwaZulu-Natal, South Africa. *South African Journal of Psychology*, *50*(3), 347–358. https://doi.org/10.1177/0081246319891635

Kumar, S. P., Dandona, R., Kumar, G. A., Ramgopal, S., & Dandona, L. (2014). Depression among AIDS-orphaned children higher than among other orphaned children in southern India. *International Journal of Mental Health Systems*, *8*(1), 13.

https://doi.org/10.1186/1752-4458-8-13

Langley, A. K., Nadeem, E., Kataoka, S. H., Stein, B. D., & Jaycox, L. H. (2010). Evidence-Based Mental Health Programs in Schools: Barriers and Facilitators of Successful Implementation. *School Mental Health*, *2*(3), 105–113. https://doi.org/10.1007/s12310-010-9038-1

Langley, E. L., Wootton, B. M., & Grieve, R. (2018). The Utility of the Health Belief Model Variables in Predicting Help-Seeking Intention for Anxiety Disorders. *Australian Psychologist*, *53*(4), 291–301. https://doi.org/10.1111/ap.12334

Leavy, P. (Ed.). (2014). *The Oxford Handbook of Qualitative Research*. Oxford University Press.

LeCompte, M. D., & Goetz, J. P. (1982). Problems of reliability and validity in Ethnographic research. *Review of Educational Research*, *52*, 31–60.

Leoschut, L., & Burton, P. (2006). *How Rich the Rewards? Results of the 2005 National Youth Victimisation Study*. www.cjcp.org.za

Leoschut, L., & Kafaar, Z. (2017). The frequency and predictors of poly-victimisation of South African children and the role of schools in its prevention. *Psychology, Health & Medicine*. https://doi.org/10.1080/13548506.2016.1273533

Liamputtong, P. (2019). Innovative Research Methods in Health Social Sciences: An Introduction. In P. Liamputtong (Ed.), *Handbook of Research Methods in Health Social Sciences* (pp. 1071–1094). Springer Singapore. https://doi.org/10.1007/978-981-10-5251-4_1

Lichtenberg, A. A., Shi, M., Joseph, K., Kaiser, B. N., & Katz, C. L. (2021). Understanding mental distress in Arcahaie, Haiti: Heterogeneous uses of idioms of distress in communicating psychological suffering. *Transcultural Psychiatry*, 136346152110005. https://doi.org/10.1177/13634615211000543

Lincoln, Y. S., & Guba, E. G. (2013). *The Constructivist Credo* (Y. S. Lincoln & E. G. Guba (Eds.)). Left Coast Press, Inc.

Loades, M. E., & Mastroyannopoulou, K. (2010). Teachers’ Recognition of Children’s Mental Health Problems. *Child and Adolescent Mental Health*, *15*(3), 150–156. https://doi.org/10.1111/j.1475-3588.2009.00551.x

Louw, D., & Louw, A. (2014). *Child and adolescent development* (2nd ed.). Psychology Publications.

Lund, C., Alem, A., Schneider, M., Hanlon, C., Ahrens, J., Bandawe, C., Bass, J., Bhana, A., Burns, J., Chibanda, D., Cowan, F., Davies, T., Dewey, M., Fekadu, A., Freeman, M., Honikman, S., Joska, J., Kagee, A., Mayston, R., … Susser, E. (2015). Generating evidence to narrow the treatment gap for mental disorders in sub-Saharan Africa: Rationale, overview and methods of AFFIRM. *Epidemiology and Psychiatric Sciences, 24*(3), 233–240. https://doi.org/10.1017/S2045796015000281

Lund, C., Petersen, I., Kleintjes, S., & Bhana, A. (2012). Mental health services in South Africa: Taking stock. *African Journal of Psychiatry (South Africa)*, *15*(6), 402–405. https://doi.org/10.4314/ajpsy.v15i6.48

Lund, Crick, Boyce, G., Flisher, A. J., Kafaar, Z., & Dawes, A. (2009). Scaling up child and adolescent mental health services in South Africa: Human resource requirements and costs. *Journal of Child Psychology and Psychiatry and Allied Disciplines*, *50*(9), 1121–1130. https://doi.org/10.1111/j.1469-7610.2009.02078.x

Lund, Crick, De Silva, M., Plagerson, S., Cooper, S., Chisholm, D., Das, J., Knapp, M., & Patel, V. (2011). Poverty and mental disorders: Breaking the cycle in low-income and middle-income countries. *The Lancet*, *378*(9801), 1502–1514. https://doi.org/10.1016/S0140-6736(11)60754-X

Lund, Crick, Schneider, M., Garman, E. C., Davies, T., Munodawafa, M., Honikman, S., Bhana, A., Bass, J., Bolton, P., Dewey, M., Joska, J., Kagee, A., Myer, L., Petersen, I., Prince, M., Stein, D. J., Tabana, H., Thornicroft, G., Tomlinson, M., … Susser, E. (2020). Task-sharing of psychological treatment for antenatal depression in Khayelitsha, South Africa: Effects on antenatal and postnatal outcomes in an individual randomised controlled trial. *Behaviour Research and Therapy*, *130*, 103466. https://doi.org/10.1016/j.brat.2019.103466

Maiuolo, M., Deane, F. P., & Ciarrochi, J. (2019). Parental Authoritativeness, Social Support and Help-seeking for Mental Health Problems in Adolescents. *Journal of Youth and Adolescence*, *48*(6), 1056–1067. https://doi.org/10.1007/s10964-019-00994-4

Malterud, K., Siersma, V. D., & Guassora, A. D. (2016). Sample Size in Qualitative Interview Studies: Guided by Information Power. *Qualitative Health Research, 26*(13), 1753–1760. https://doi.org/10.1177/1049732315617444

Maphumulo, W. T., & Bhengu, B. R. (2019). Challenges of quality improvement in the healthcare of South Africa post-apartheid: A critical review. *Curationis*, *42*(1), 233–240. https://doi.org/10.4102/curationis.v42i1.1901

Mason, J. (1996). *Qualitative Researching*. SAGE.

Maxwell, J. A. (2013). *Qualitative research design: An interactive approach*. SAGE.

Mayberry, D., Reupert, A., Nicholson, J., Gopfert, J., & Seeman, M. (2015). Are we there yet? Developing a conceptual framework for understanding families where a parent has a mental illness. In D. Mayberry, A. Reupert, J. Nicholson, J. Gopfert, & M. Seeman (Eds.), *Parental psychiatric disorder: Distressed parents and their families* (3rd ed., pp. 365–370). Cambridge University Press.

Mays, N., & Pope, C. (2000). Assessing quality in qualitative research. *BMJ*, *320*(7226), 50–52. https://doi.org/10.1136/bmj.320.7226.50

Mayston, R., Frissa, S., Tekola, B., Hanlon, C., Prince, M., & Fekadu, A. (2020). Explanatory models of depression in sub-Saharan Africa: Synthesis of qualitative evidence. *Social Science and Medicine*, *246*(December 2019), 112760. https://doi.org/10.1016/j.socscimed.2019.112760

McCambridge, J., de Bruin, M., & Witton, J. (2012). The Effects of Demand Characteristics on Research Participant Behaviours in Non-Laboratory Settings: A Systematic Review. *PLoS ONE*, *7*(6), e39116. https://doi.org/10.1371/journal.pone.0039116

Meinck, F., Cluver, L. D., Boyes, M. E., & Loening-Voysey, H. (2016). Physical, emotional and sexual adolescent abuse victimisation in South Africa: prevalence, incidence, perpetrators and locations. *Journal of Epidemiology and Community Health*, *70*(9), 910–916. https://doi.org/10.1136/jech-2015-205860

Meinck, F., Cluver, L. D., Boyes, M. E., & Ndhlovu, L. D. (2015). Risk and Protective Factors for Physical and Emotional Abuse Victimisation amongst Vulnerable Children in South Africa. *Child Abuse Review*, *24*(3), 182–197. https://doi.org/10.1002/car.2283

Meinck, F., Cluver, L. D., Orkin, F. M., Kuo, C., Sharma, A. D., Hensels, I. S., & Sherr, L. (2017). Pathways From Family Disadvantage via Abusive Parenting and Caregiver Mental Health to Adolescent Health Risks in South Africa. *Journal of Adolescent*

Health, *60*(1), 57–64. https://doi.org/10.1016/j.jadohealth.2016.08.016

Merikangas, K. R., He, J., Burstein, M., Swendsen, J., Avenevoli, S., Case, B., Georgiades, K., Heaton, L., Swanson, S., & Olfson, M. (2011). Service Utilization for Lifetime Mental Disorders in U.S. Adolescents: Results of the National Comorbidity Survey–Adolescent Supplement (NCS-A). *Journal of the American Academy of Child & Adolescent Psychiatry*, *50*(1), 32–45. https://doi.org/10.1016/j.jaac.2010.10.006

Mohamed-Kaloo, Z., & Laher, S. (2014). Perceptions of mental illness among muslim general practitioners in South Africa. *South African Medical Journal*, *104*(5), 350–352. https://doi.org/10.7196/SAMJ.7863

Mokitimi, S., Jonas, K., Schneider, M., & de Vries, P. J. (2019). Child and Adolescent Mental Health Services in South Africa—Senior Stakeholder Perceptions of Strengths, Weaknesses, Opportunities, and Threats in the Western Cape Province. *Frontiers in Psychiatry*, *10*(November), 1–13. https://doi.org/10.3389/fpsyt.2019.00841

Mokitimi, S., Schneider, M., & de Vries, P. J. (2018). Child and adolescent mental health policy in South Africa: History, current policy development and implementation, and policy analysis. *International Journal of Mental Health Systems*, *12*(1), 1–15. https://doi.org/10.1186/s13033-018-0213-3

Morris, J., Belfer, M., Daniels, A., Flisher, A., Ville, L., Lora, A., & Saxena, S. (2011). *Treated prevalence of and mental health services received by children and adolescents in 42 low-and-middle-income countries*. *52*(12), 1239–1246. https://doi.org/10.1111/j.1469-7610.2011.02409.x

Muga, F. A., & Jenkins, R. (2008). Public perceptions, explanatory models and service utilisation regarding mental illness and mental health care in Kenya. *Social Psychiatry and Psychiatric Epidemiology*, *43*(6), 469–476. https://doi.org/10.1007/s00127-008-0334-0

Munodawafa, M., Mall, S., Lund, C., & Schneider, M. (2018). Process evaluations of task sharing interventions for perinatal depression in low and middle income countries (LMIC): a systematic review and qualitative meta-synthesis. *BMC Health Services Research*, *18*(1), 205. https://doi.org/10.1186/s12913-018-3030-0

O’Connell, M. E., Boat, T. E., & Warner, K. E. (2009). Defining the scope of prevention. In

M. E. O'Connell, T. E. Boat, & K. E. Warner (Eds.), *Preventing mental, emotional, and behavioral disorders among young people: Progress and possibilities.* (pp. 59–71). The National Academies Press.

Ofonedu, M. E., Belcher, H. M. E., Budhathoki, C., & Gross, D. A. (2017). Understanding Barriers to Initial Treatment Engagement among Underserved Families Seeking Mental Health Services. *Journal of Child and Family Studies*, *26*(3), 863–876. https://doi.org/10.1007/s10826-016-0603-6

Ogundele, M. O. (2018). Behavioural and emotional disorders in childhood: A brief overview for paediatricians. *World Journal of Clinical Pediatrics, 7*(1), 9–26. https://doi.org/10.5409/wjcp.v7.i1.9

Ohan, J. L., Seward, R. J., Stallman, H. M., Bayliss, D. M., & Sanders, M. R. (2015). Parents' Barriers to Using School Psychology Services for Their Child's Mental Health Problems. *School Mental Health*, *7*(4), 287–297. https://doi.org/10.1007/s12310-015-9152-1

Osborn, T. L., Wasil, A. R., Weisz, J. R., Kleinman, A., & Ndetei, D. M. (2020). Where is the global in global mental health? A call for inclusive multicultural collaboration. *General Psychiatry*, *33*(6), e100351. https://doi.org/10.1136/gpsych-2020-100351

Ozer, E. J., Lavi, I., Douglas, L., & Wolf, J. P. (2017). Protective Factors for Youth Exposed to Violence in Their Communities: A Review of Family, School, and Community Moderators. *Journal of Clinical Child and Adolescent Psychology*, *46*(3), 353–378. https://doi.org/10.1080/15374416.2015.1046178

Pang, L. H. G., & Thomas, S. J. (2020). Exposure to Domestic Violence during Adolescence: Coping Strategies and Attachment Styles as Early Moderators and their Relationship to Functioning during Adulthood. *Journal of Child & Adolescent Trauma*, *13*(2), 185–198. https://doi.org/10.1007/s40653-019-00279-9

Patel, V., Flisher, A. J., Hetrick, S., & McGorry, P. (2007). Mental health of young people: a global public-health challenge. *The Lancet*, *369*(9569), 1302–1313. https://doi.org/10.1016/S0140-6736(07)60368-7

Patel, V., Lund, C., Hatherill, S., Plagerson, S., Corrigall, J., Funk, M., & Flisher, A. J. (2010). Mental disorders: equity and social determinants. In E. Blas & A. S. Kurup

(Eds.), *Equity, social determinants and public health programmes* (pp. 115–134). World Health Organization. https://doi.org/10.2323/jgam.51.385

Patel, V., Belkin, G. S., Chockalingam, A., Cooper, J., Saxena, S., & Unützer, J. (2013). Grand Challenges: Integrating Mental Health Services into Priority Health Care Platforms. *PLoS Medicine*, *10*(5). https://doi.org/10.1371/journal.pmed.1001448

Patel, V., Flisher, A. J., Hetrick, S., & McGorry, P. (2007). Mental health of young people: a global public-health challenge. *The Lancet*, *369*(9569), 1302–1313. https://doi.org/10.1016/S0140-6736(07)60368-7

Patel, V., Maj, M., Flisher, A. J., De Silva, M. J., Koschorke, M., Prince, M., Tempier, R., Riba, M. B., Sanchez, M., Campodonico, F. D., Risco, L., Gask, L., Wahlberg, H., Roca, M., Lecic-Tosevski, D., Soghoyan, A., Moussaoui, D., Baddoura, C., Adeyemi, J., … Richardson, G. (2010). Reducing the treatment gap for mental disorders: A WPA survey. *World Psychiatry*, *9*(3), 169–176. https://doi.org/10.1002/j.2051-5545.2010.tb00305.x

Patel, V., & Rahman, A. (2015). Editorial Commentary: An agenda for global child mental health. *Child and Adolescent Mental Health*, *20*(1), 3–4. https://doi.org/10.1111/camh.12083

Paulus, F. W., Ohmann, S., & Popow, C. (2016). Practitioner Review : School-based interventions in child mental health. *The Journal of Child Psychology and Psychiatry*, *57*(12), 1337–1359. https://doi.org/10.1111/jcpp.12584

Pedersen, G. A., Smallegange, E., Coetzee, A., Hartog, K., Turner, J., Jordans, M. J. D., & Brown, F. L. (2019). A Systematic Review of the Evidence for Family and Parenting Interventions in Low- and Middle-Income Countries: Child and Youth Mental Health Outcomes. *Journal of Child and Family Studies*, *28*(8), 2036–2055. https://doi.org/10.1007/s10826-019-01399-4

Pengpid, S., & Peltzer, K. (2021). Associations of number of victimizations with mental health indicators and health-risk behaviours among a nationally representative sample of in-school adolescents in Curaçao. *Child Abuse & Neglect*, *111*(December 2020), 104831. https://doi.org/10.1016/j.chiabu.2020.104831

Perold, M. D. (2001). *the Prevalence of Anxiety in a Group of 7 To 13 Year Old Learners in* *the Western Cape* (Issue December). University of Stellenbosch.

Petersen, C. (2019). *Mental health literacy of undergraduate nursing students at a university in the Western Cape* (Issue November). University of the Western Cape.

Petersen, I., & Lund, C. (2011). Mental health service delivery in South Africa from 2000 to 2010: One step forward, one step back. *South African Medical Journal*, *101*(10), 751–757. http://www.samj.org.za/index.php/samj/article/view/4841/3442%5Cnhttp://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=emed10&NEWS=N&AN=2011542801

Pham, T. V., Koirala, R., Wainberg, M. L., & Kohrt, B. A. (2021). Reassessing the Mental Health Treatment Gap: What Happens if We Include the Impact of Traditional Healing on Mental Illness? *Community Mental Health Journal*, *57*(4), 777–791. https://doi.org/10.1007/s10597-020-00705-5

Polanczyk, G. V., Salum, G. A., Sugaya, L. S., Caye, A., & Rohde, L. A. (2015). Annual research review: A meta-analysis of the worldwide prevalence of mental disorders in children and adolescents. *Journal of Child Psychology and Psychiatry and Allied Disciplines*, *56*(3), 345–365. https://doi.org/10.1111/jcpp.12381

Poole, L. A., Knight, T., Toumbourou, J. W., Lubman, D. I., Bertino, M. D., & Lewis, A. J. (2018). A Randomized Controlled Trial of the Impact of a Family-Based Adolescent Depression Intervention on both Youth and Parent Mental Health Outcomes. *Journal of Abnormal Child Psychology*, *46*(1), 169–181. https://doi.org/10.1007/s10802-017-0292-7

Posel, D., Oyenubi, A., & Kollamparambil, U. (2021). Job loss and mental health during the COVID- 19 lockdown: Evidence from South Africa. *PLoS ONE*, *16*(3 March), 1–15. https://doi.org/10.1371/journal.pone.0249352

Ramalho, R., Adams, P., Huggard, P., & Hoare, K. (2015). Literature review and constructivist grounded theory methodology. *Forum Qualitative Sozialforschung*, *16*(3). https://doi.org/10.17169/fqs-16.3.2313

Ramlall, S., Chipps, J., & Mars, M. (2010). Impact of the South African Mental Health Care Act No. 17 of 2002 on regional and district hospitals designated for mental health care in KwaZulu-Natal. *South African Medical Journal*, *100*, 667–670.

Rapsey, C. M., Scott, K. M., & Patterson, T. (2019). Childhood sexual abuse, poly-victimization and internalizing disorders across adulthood and older age: Findings from a 25-year longitudinal study. *Journal of Affective Disorders*, *244*(September 2018), 171–179. https://doi.org/10.1016/j.jad.2018.10.095

Reardon, T., Harvey, K., Baranowska, M., O’Brien, D., Smith, L., & Creswell, C. (2017). What do parents perceive are the barriers and facilitators to accessing psychological treatment for mental health problems in children and adolescents? A systematic review of qualitative and quantitative studies. *European Child and Adolescent Psychiatry*, *26*(6), 623–647. https://doi.org/10.1007/s00787-016-0930-6

Reardon, T., Harvey, K., & Creswell, C. (2020). Seeking and accessing professional support for child anxiety in a community sample. *European Child & Adolescent Psychiatry*, *29*(5), 649–664. https://doi.org/10.1007/s00787-019-01388-4

Reardon, T., Harvey, K., Young, B., O’Brien, D., & Creswell, C. (2018). Barriers and facilitators to parents seeking and accessing professional support for anxiety disorders in children: qualitative interview study. *European Child and Adolescent Psychiatry*, *27*(8), 1023–1031. https://doi.org/10.1007/s00787-018-1107-2

Roberts, T., Miguel Esponda, G., Krupchanka, D., Shidhaye, R., Patel, V., & Rathod, S. (2018). Factors associated with health service utilisation for common mental disorders: a systematic review. *BMC Psychiatry*, *18*(1), 262. https://doi.org/10.1186/s12888-018-1837-1

Rosenstock, I. M. (2005). Why People Use Health Services. *Milbank Quarterly*, *83*(4), Online-only-Online-only. https://doi.org/10.1111/j.1468-0009.2005.00425.x

Ryan, S. M., Jorm, A. F., Toumbourou, J. W., & Lubman, D. I. (2015). Parent and family factors associated with service use by young people with mental health problems: a systematic review. *Early Intervention in Psychiatry*, *9*(6), 433–446. https://doi.org/10.1111/eip.12211

Santiago, C. D., Kaltman, S., & Miranda, J. (2013). Poverty and Mental Health: How Do Low-Income Adults and Children Fare in Psychotherapy? *Journal of Clinical Psychology*, *69*(2), 115–126. https://doi.org/10.1002/jclp.21951

Sarikhani, Y., Bastani, P., Rafiee, M., Kavosi, Z., & Ravangard, R. (2020). Key Barriers to the Provision and Utilization of Mental Health Services in Low-and Middle-Income Countries: A Scope Study. *Community Mental Health Journal*, *0123456789*. https://doi.org/10.1007/s10597-020-00619-2

Saxena, S., Thornicroft, G., Knapp, M., & Whiteford, H. (2007). Resources for mental health: scarcity, inequity, and inefficiency. *The Lancet*, *370*(9590), 878–889. https://doi.org/10.1016/S0140-6736(07)61239-2

Schneider, M., Baron, E., Breuer, E., Docrat, S., Honikman, S., Kagee, A., Onah, M., Skeen, S., Sorsdahl, K., Tomlinson, M., van der Westhuizen, C., & Lund, C. (2016). Integrating mental health into South Africa's health system: current status and way forward. *South African Health Review*. https://doi.org/10520/EJC189311

Schneider, M., Baron, E., Breuer, E., Docrat, S., Honikman, S., Onah, M., Sorsdahl, K., van der Westhuizen, C., Lund, C., Kagee, A., Skeen, S., & Tomlinson, M. (2016). Analysis of the pathway of developing a national mental health plan for. *South African Health Reveiw 2016*, *2016*(1), 153–163.

Seedat, S., Williams, D. R., Herman, A. A., Moomal, H., Williams, S. L., Jackson, P. B., & Myer, L. (2009). Mental health service use among South Africans for mood, anxiety and substance use disorders. *South African Medical Journal*, *99*, 346–352.

Seedat, Soraya, Stein, D. J., Herman, A., Kessler, R., Sonnega, J., Heeringa, S., Williams, S., & Williams, D. (2008). Twelve-month treatment of psychiatric disorders in the South African Stress and Health Study (World Mental Health Survey Initiative). *Social Psychiatry and Psychiatric Epidemiology*, *43*(11), 889–897. https://doi.org/10.1007/s00127-008-0399-9

Sennott, C., & A. Mojola, S. (2017). 'Behaving well': the transition to respectable womanhood in rural South Africa. *Culture, Health & Sexuality*, *19*(7), 781–795. https://doi.org/10.1080/13691058.2016.1262062

Serbin, L. A., Kingdon, D., Ruttle, P. L., & Stack, D. M. (2015). The impact of children's internalizing and externalizing problems on parenting: Transactional processes and reciprocal change over time. *Development and Psychopathology*, *27*(4pt1), 969–986. https://doi.org/10.1017/S0954579415000632

Shenderovich, Y., Eisner, M., Cluver, L., Doubt, J., Berezin, M. K., Majokweni, S., &

Murray, A. L. (2018). What Affects Attendance and Engagement in a Parenting Program in South Africa? *Prevention Science*, *19*(7), 977–986. https://doi.org/10.1007/s11121-018-0941-2

Sifaki, M., Midouhas, E., Papachristou, E., & Flouri, E. (2020). Reciprocal relationships between paternal psychological distress and child internalising and externalising difficulties from 3 to 14 years: a cross-lagged analysis. *European Child and Adolescent Psychiatry*, *0123456789*. https://doi.org/10.1007/s00787-020-01642-0

Skeen, S., Laurenzi, C. A., Gordon, S. L., du Toit, S., Tomlinson, M., Dua, T., Fleischmann, A., Kohl, K., Ross, D., Servili, C., Brand, A. S., Dowdall, N., Lund, C., van der Westhuizen, C., Carvajal-Aguirre, L., Eriksson de Carvalho, C., & Melendez-Torres, G. J. (2019). Adolescent Mental Health Program Components and Behavior Risk Reduction: A Meta-analysis. *Pediatrics*, *144*(2), e20183488. https://doi.org/10.1542/peds.2018-3488

Skinner, D., Sharp, C., Marais, L., Serekoane, M., & Lenka, M. (2019). A qualitative study on teachers' perceptions of their learners' mental health problems in a disadvantaged community in South Africa. *Curationis*, *42*(1). https://doi.org/10.4102/curationis.v42i1.1903

Skylstad, V., Akol, A., Ndeezi, G., Nalugya, J., Moland, K. M., Tumwine, J. K., & Engebretsen, I. M. S. (2019). Child mental illness and the help-seeking process: A qualitative study among parents in a Ugandan community. *Child and Adolescent Psychiatry and Mental Health*, *13*(1), 1–13. https://doi.org/10.1186/s13034-019-0262-7

Sorsdahl, K. R., Flisher, A. J., Wilson, Z., & Stein, D. J. (2010). Explanatory models of mental disorders and treatment practices among traditional healers in Mpumulanga, South Africa. *African Journal of Psychiatry (South Africa)*, *13*(4), 284–290. https://doi.org/10.4314/ajpsy.v13i4.61878

Sorsdahl, Katherine R., Mall, S., Stein, D. J., & Joska, J. A. (2010). Perspectives towards mental illness in people living with HIV/AIDS in South Africa. *AIDS Care*, *22*(11), 1418–1427. https://doi.org/10.1080/09540121003758655

Spedding, M. F., Stein, D. J., Naledi, T., & Sorsdahl, K. (2018). Pregnant women's mental health literacy and perceptions of perinatal mental disorders in the Western Cape, South Africa. *Mental Health & Prevention*, *11*, 16–23.

https://doi.org/10.1016/j.mhp.2018.05.002

Steel, Z., Marnane, C., Iranpour, C., Chey, T., Jackson, J. W., Patel, V., & Silove, D. (2014). The global prevalence of common mental disorders: A systematic review and meta-analysis 1980-2013. *International Journal of Epidemiology*, *43*(2), 476–493. https://doi.org/10.1093/ije/dyu038

Strümpher, J., Van Rooyen, R. M., Topper, K., Andersson, L. M. C., & Schierenback, I. (2016). Barriers to accessing mental health care in the Eastern Cape province of South Africa. *Africa Journal of Nursing and Midwifery*, *16*(1), 45–59. https://doi.org/10.25159/2520-5293/1487

Suldo, S. M., Gormley, M. J., DuPaul, G. J., & Anderson-Butcher, D. (2014). The Impact of School Mental Health on Student and School-Level Academic Outcomes: Current Status of the Research and Future Directions. *School Mental Health*, *6*(2), 84–98. https://doi.org/10.1007/s12310-013-9116-2

Swedberg, R. (2020). Exploratory research. In C. Elman, J. Gerring, & J. Mahoney (Eds.), *The production of knowledge: Enhancing progress in social science* (pp. 2–41). Cambridge University Press.

The Belmont report: Ethical principles and guidelines for the protection of human subjects of research. (1978).

Thulsile Zita, C. (2018). *Mental Health Literacy of Young People in South Africa: A Study of University of KwaZulu-Natal Students*. University of KwaZulu-Natal.

Tomczyk, S., Schomerus, G., Stolzenburg, S., Muehlan, H., & Schmidt, S. (2020). Ready, Willing and Able? An Investigation of the Theory of Planned Behaviour in Help-Seeking for a Community Sample with Current Untreated Depressive Symptoms. *Prevention Science*, *21*(6), 749–760. https://doi.org/10.1007/s11121-020-01099-2

Trickey, D., Siddaway, A. P., Meiser-Stedman, R., Serpell, L., & Field, A. P. (2012). A meta-analysis of risk factors for post-traumatic stress disorder in children and adolescents. *Clinical Psychology Review*, *32*(2), 122–138. https://doi.org/10.1016/j.cpr.2011.12.001

Tully, L. A., Hawes, D. J., Doyle, F. L., Sawyer, M. G., & Dadds, M. R. (2019). A national child mental health literacy initiative is needed to reduce childhood mental health disorders. *Australian & New Zealand Journal of Psychiatry*, *53*(4), 286–290.

https://doi.org/10.1177/0004867418821440

UNICEF. (2021). *HIV/AIDS Global and regional trends*. https://data.unicef.org/topic/hivaids/global-regional-trends/

Vigo, D., Thornicroft, G., & Atun, R. (2016). Estimating the true global burden of mental illness. *The Lancet Psychiatry*, *3*(2), 171–178. https://doi.org/10.1016/S2215-0366(15)00505-2

Votruba, N., & Thornicroft, G. (2016). Sustainable development goals and mental health: learnings from the contribution of the FundaMentalSDG global initiative. *Global Mental Health*, *3*, e26. https://doi.org/10.1017/gmh.2016.20

Wahlin, T., & Deane, F. (2012). Discrepancies between parent- and adolescent-perceived problem severity and influences on help seeking from mental health services. *Australian & New Zealand Journal of Psychiatry*, *46*(6), 553–560. https://doi.org/10.1177/0004867412441929

Wang, P. S., Aguilar-Gaxiola, S., Alonso, J., Angermeyer, M. C., Borges, G., Bromet, E. J., Bruffaerts, R., de Girolamo, G., de Graaf, R., Gureje, O., Haro, J. M., Karam, E. G., Kessler, R. C., Kovess, V., Lane, M. C., Lee, S., Levinson, D., Ono, Y., Petukhova, M., … Wells, J. E. (2007). Use of mental health services for anxiety, mood, and substance disorders in 17 countries in the WHO world mental health surveys. *The Lancet*, *370*(9590), 841–850. https://doi.org/10.1016/S0140-6736(07)61414-7

Ward, C., Makusha, T., & Bray, R. (2015). Parenting, poverty and young people in South Africa: What are the connections? In *South african child gauge* (Issue November).

Weist, M. D., Youngstrom, E. A., Stephan, S., Lever, N., Fowler, J., Taylor, L., McDaniel, H., Chappelle, L., Paggeot, S., & Hoagwood, K. (2014). Challenges and Ideas from a Research Program on High-Quality, Evidence-Based Practice in School Mental Health. *Journal of Clinical Child & Adolescent Psychology*, *43*(2), 244–255. https://doi.org/10.1080/15374416.2013.833097

Wessels, I., Lester, S., & Ward, C. L. (2016). *Engagement in parenting programmes*. *March*.

WHO. (2017). Global Burden of Disease Study 2017. In *The Lancet*.

Williams, D. R., Herman, A., Stein, D. J., Heeringa, S. G., Jackson, P. B., Moomal, H., & Kessler, R. C. (2008). Twelve-month mental disorders in South Africa: prevalence, service use and demographic correlates in the population-based South African Stress and Health Study. *Psychological Medicine*, *38*(2), 211–220. https://doi.org/10.1017/S0033291707001420

Willig, C. (2008). *Qualitative Research* (C. Willig (Ed.); 2nd ed.). Open University Press.

Woollett, N., Cluver, L., Bandeira, M., & Brahmbhatt, H. (2017). Identifying risks for mental health problems in HIV positive adolescents accessing HIV treatment in Johannesburg. *Journal of Child and Adolescent Mental Health*, *29*(1), 11–26. https://doi.org/10.2989/17280583.2017.1283320

World Health Organization. (2004). *Disease and injury regional estimates for 2004*. http://www.who.int/ healthinfo/global burden disease/estimates regional/en/index.html.

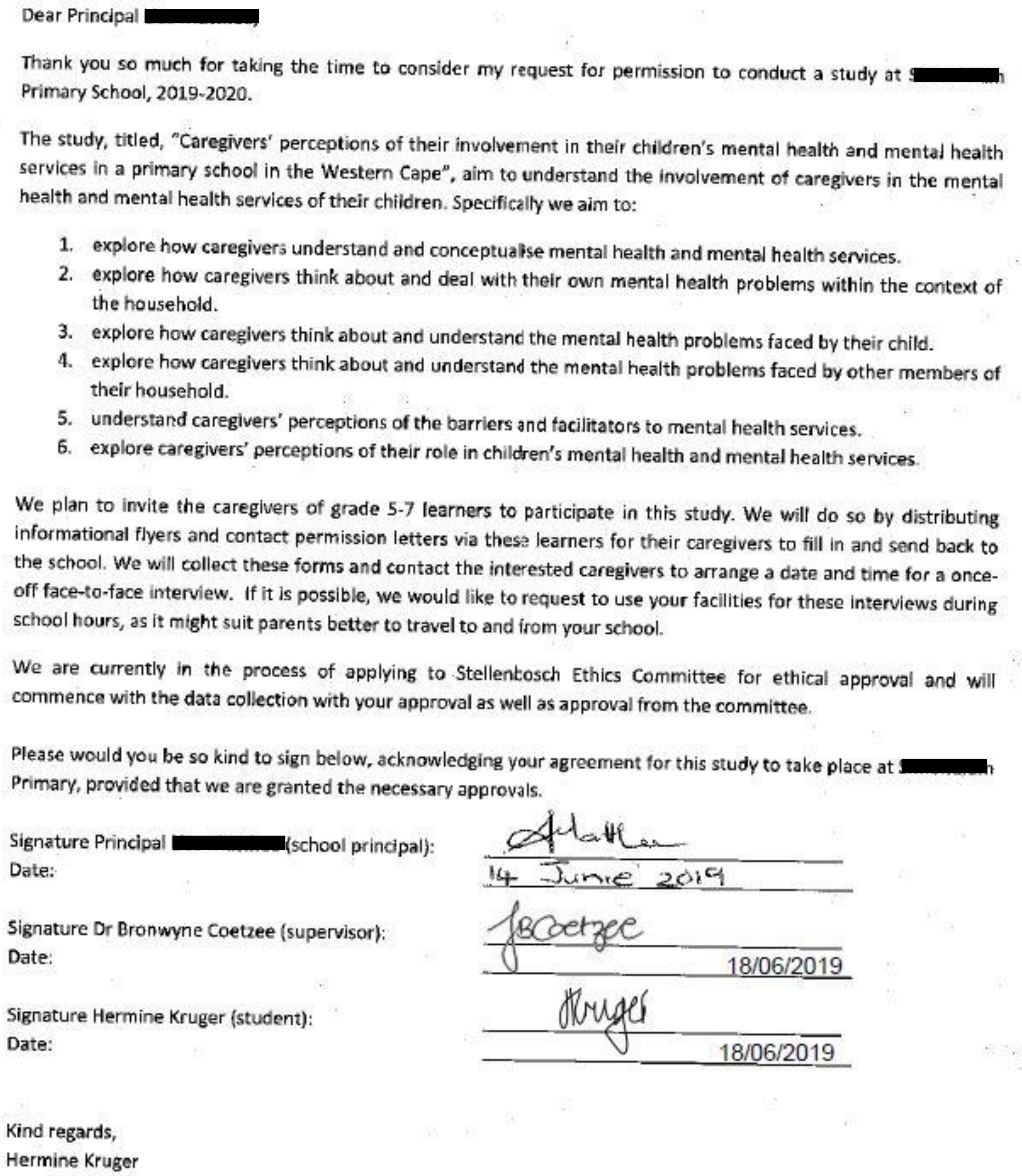
World Health Organization. (2011). *Mental health atlas 2011*.

World Health Organization. (2017). *Depression and other common mental disorders: Global health estimates*. https://apps.who.int/iris/bitstream/handle/10665/254610/WHO-MSD-MER-2017.2-eng.pdf

Xu, Z., Huang, F., Kösters, M., Staiger, T., Becker, T., Thornicroft, G., & Rüsch, N. (2018). Effectiveness of interventions to promote help-seeking for mental health problems: systematic review and meta-analysis. *Psychological Medicine*, *48*(16), 2658–2667. https://doi.org/10.1017/S0033291718001265

Yap, M. B. H., Morgan, A. J., Cairns, K., Jorm, A. F., Hetrick, S. E., & Merry, S. (2016). Parents in prevention: A meta-analysis of randomized controlled trials of parenting interventions to prevent internalizing problems in children from birth to age 18. *Clinical Psychology Review*, *50*, 138–158. https://doi.org/10.1016/j.cpr.2016.10.003

Appendix A: Permission letter from principal of the selected primary school



Dear Principal [redacted]

Thank you so much for taking the time to consider my request for permission to conduct a study at [redacted] Primary School, 2019-2020.

The study, titled, "Caregivers' perceptions of their involvement in their children's mental health and mental health services in a primary school in the Western Cape", aim to understand the involvement of caregivers in the mental health and mental health services of their children. Specifically we aim to:

1. explore how caregivers understand and conceptualise mental health and mental health services.
2. explore how caregivers think about and deal with their own mental health problems within the context of the household.
3. explore how caregivers think about and understand the mental health problems faced by their child.
4. explore how caregivers think about and understand the mental health problems faced by other members of their household.
5. understand caregivers' perceptions of the barriers and facilitators to mental health services.
6. explore caregivers' perceptions of their role in children's mental health and mental health services.

We plan to invite the caregivers of grade 5-7 learners to participate in this study. We will do so by distributing informational flyers and contact permission letters via these learners for their caregivers to fill in and send back to the school. We will collect these forms and contact the interested caregivers to arrange a date and time for a once-off face-to-face interview. If it is possible, we would like to request to use your facilities for these interviews during school hours, as it might suit parents better to travel to and from your school.

We are currently in the process of applying to Stellenbosch Ethics Committee for ethical approval and will commence with the data collection with your approval as well as approval from the committee.

Please would you be so kind to sign below, acknowledging your agreement for this study to take place at [redacted] Primary, provided that we are granted the necessary approvals.

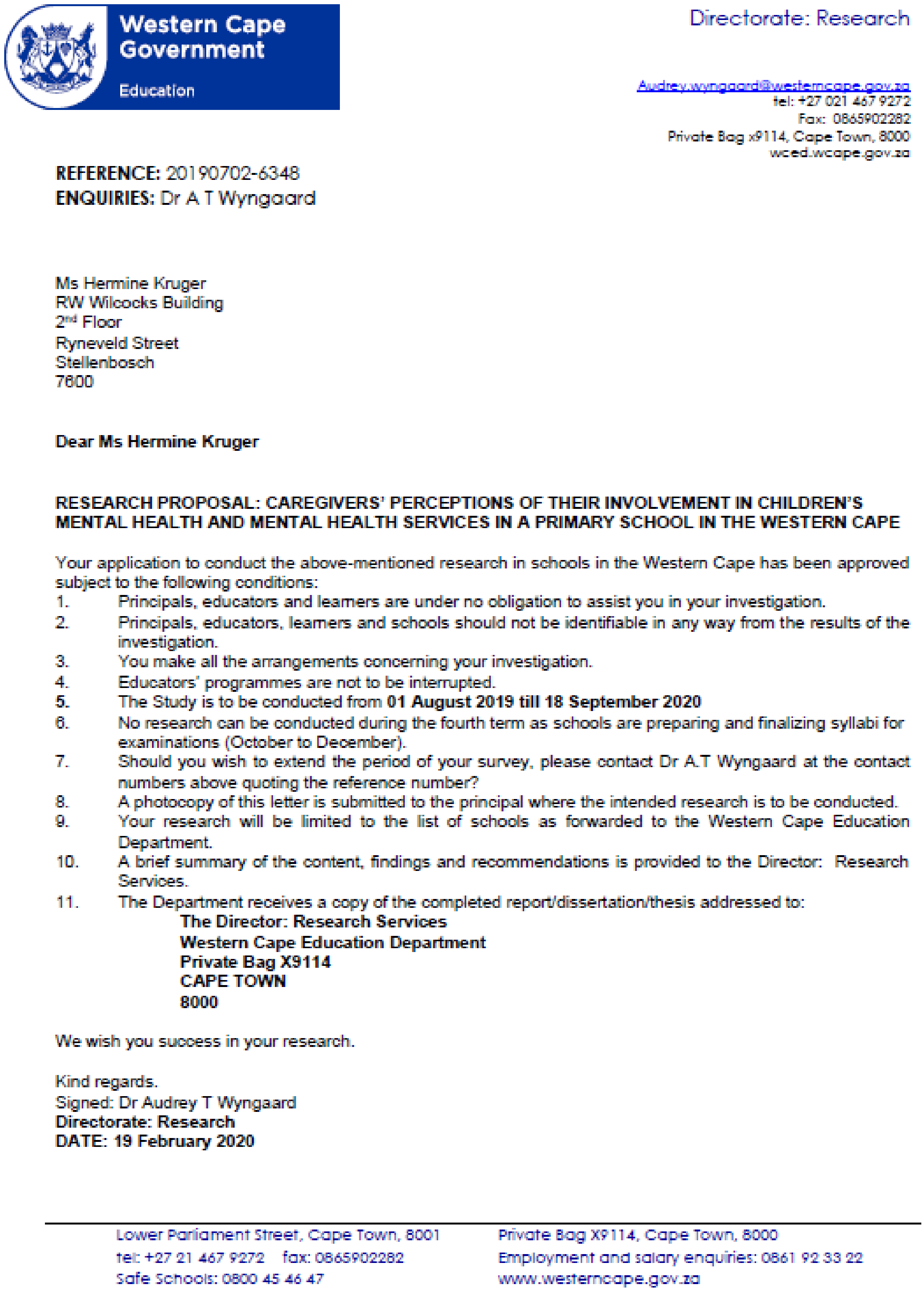
Signature Principal [redacted] (school principal):
Date: 14 June 2019

Signature Dr Bronwyne Coetzee (supervisor): JBCoetzee
Date: 18/06/2019

Signature Hermine Kruger (student): HKruger
Date: 18/06/2019

Kind regards,
Hermine Kruger

Appendix B1: Permission letter from the Western Cape Education Department



Western Cape Government
Education

Directorate: Research

Audrey.wyngaard@westerncape.gov.za
tel: +27 021 467 9272
Fax: 0865902282
Private Bag x9114, Cape Town, 8000
wced.wcape.gov.za

REFERENCE: 20190702-6348
ENQUIRIES: Dr A T Wyngaard

Ms Hermine Kruger
RW Wilcocks Building
2nd Floor
Ryneveld Street
Stellenbosch
7600

Dear Ms Hermine Kruger

RESEARCH PROPOSAL: CAREGIVERS' PERCEPTIONS OF THEIR INVOLVEMENT IN CHILDREN'S MENTAL HEALTH AND MENTAL HEALTH SERVICES IN A PRIMARY SCHOOL IN THE WESTERN CAPE

Your application to conduct the above-mentioned research in schools in the Western Cape has been approved subject to the following conditions:

1. Principals, educators and learners are under no obligation to assist you in your investigation.
2. Principals, educators, learners and schools should not be identifiable in any way from the results of the investigation.
3. You make all the arrangements concerning your investigation.
4. Educators' programmes are not to be interrupted.
5. The Study is to be conducted from **01 August 2019 till 18 September 2020**
6. No research can be conducted during the fourth term as schools are preparing and finalizing syllabi for examinations (October to December).
7. Should you wish to extend the period of your survey, please contact Dr A.T Wyngaard at the contact numbers above quoting the reference number?
8. A photocopy of this letter is submitted to the principal where the intended research is to be conducted.
9. Your research will be limited to the list of schools as forwarded to the Western Cape Education Department.
10. A brief summary of the content, findings and recommendations is provided to the Director: Research Services.
11. The Department receives a copy of the completed report/dissertation/thesis addressed to:

The Director: Research Services
Western Cape Education Department
Private Bag X9114
CAPE TOWN
8000

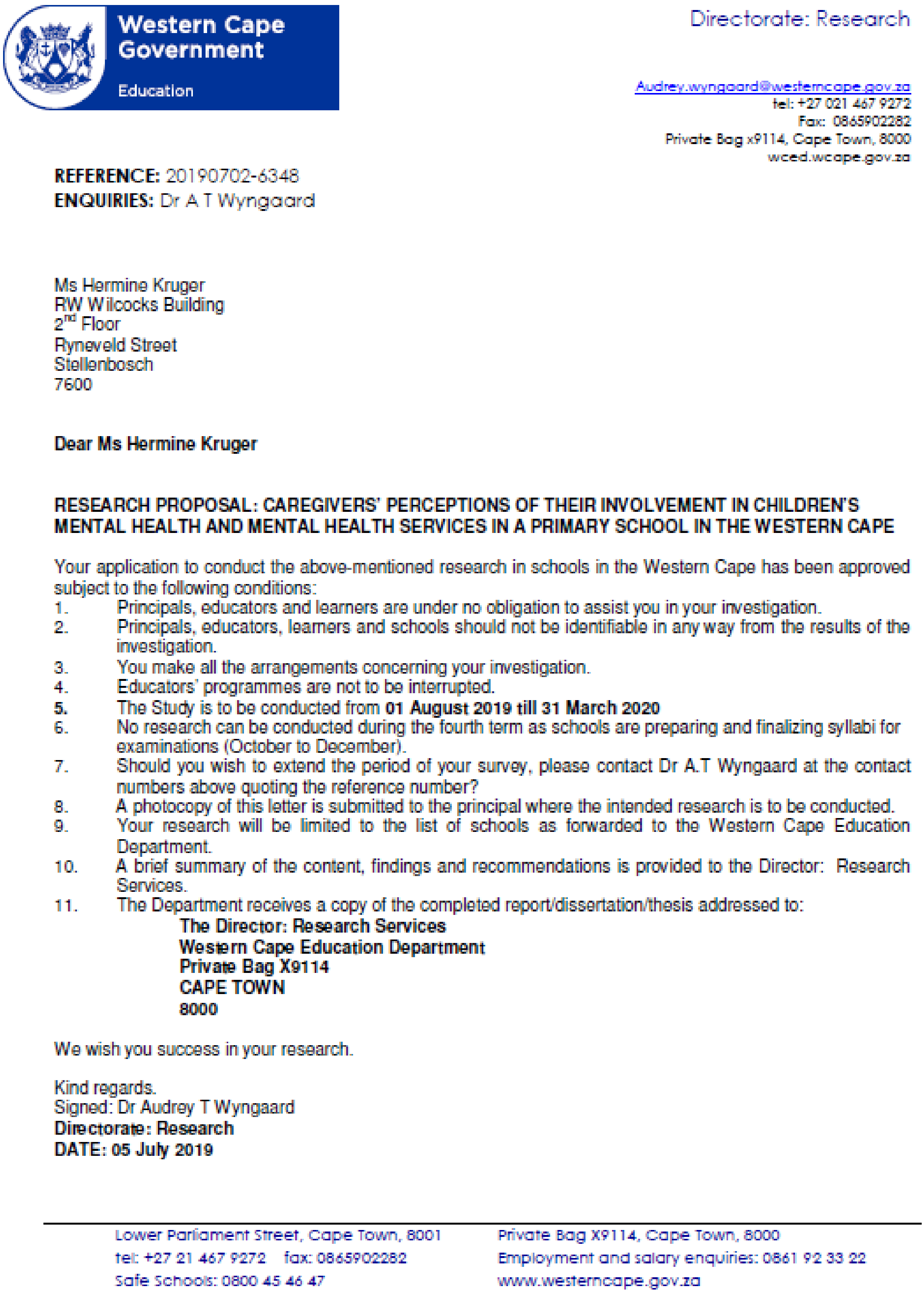
We wish you success in your research.

Kind regards.
Signed: Dr Audrey T Wyngaard
Directorate: Research
DATE: 19 February 2020

Lower Parliament Street, Cape Town, 8001
tel: +27 21 467 9272 fax: 0865902282
Safe Schools: 0800 45 46 47

Private Bag X9114, Cape Town, 8000
Employment and salary enquiries: 0861 92 33 22
www.westerncape.gov.za

Appendix B2: Permission letter from Western Cape Education Department following request for extension



Western Cape Government
Education

Directorate: Research

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tel: +27 021 467 9272
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REFERENCE: 20190702-6348
ENQUIRIES: Dr A T Wyngaard

Ms Hermine Kruger
RW Wilcocks Building
2nd Floor
Ryneveld Street
Stellenbosch
7600

Dear Ms Hermine Kruger

RESEARCH PROPOSAL: CAREGIVERS' PERCEPTIONS OF THEIR INVOLVEMENT IN CHILDREN'S MENTAL HEALTH AND MENTAL HEALTH SERVICES IN A PRIMARY SCHOOL IN THE WESTERN CAPE

Your application to conduct the above-mentioned research in schools in the Western Cape has been approved subject to the following conditions:

1. Principals, educators and learners are under no obligation to assist you in your investigation.
2. Principals, educators, learners and schools should not be identifiable in any way from the results of the investigation.
3. You make all the arrangements concerning your investigation.
4. Educators' programmes are not to be interrupted.
5. The Study is to be conducted from **01 August 2019 till 31 March 2020**
6. No research can be conducted during the fourth term as schools are preparing and finalizing syllabi for examinations (October to December).
7. Should you wish to extend the period of your survey, please contact Dr A.T Wyngaard at the contact numbers above quoting the reference number?
8. A photocopy of this letter is submitted to the principal where the intended research is to be conducted.
9. Your research will be limited to the list of schools as forwarded to the Western Cape Education Department.
10. A brief summary of the content, findings and recommendations is provided to the Director: Research Services.
11. The Department receives a copy of the completed report/dissertation/thesis addressed to:

    The Director: Research Services
    Western Cape Education Department
    Private Bag X9114
    CAPE TOWN
    8000

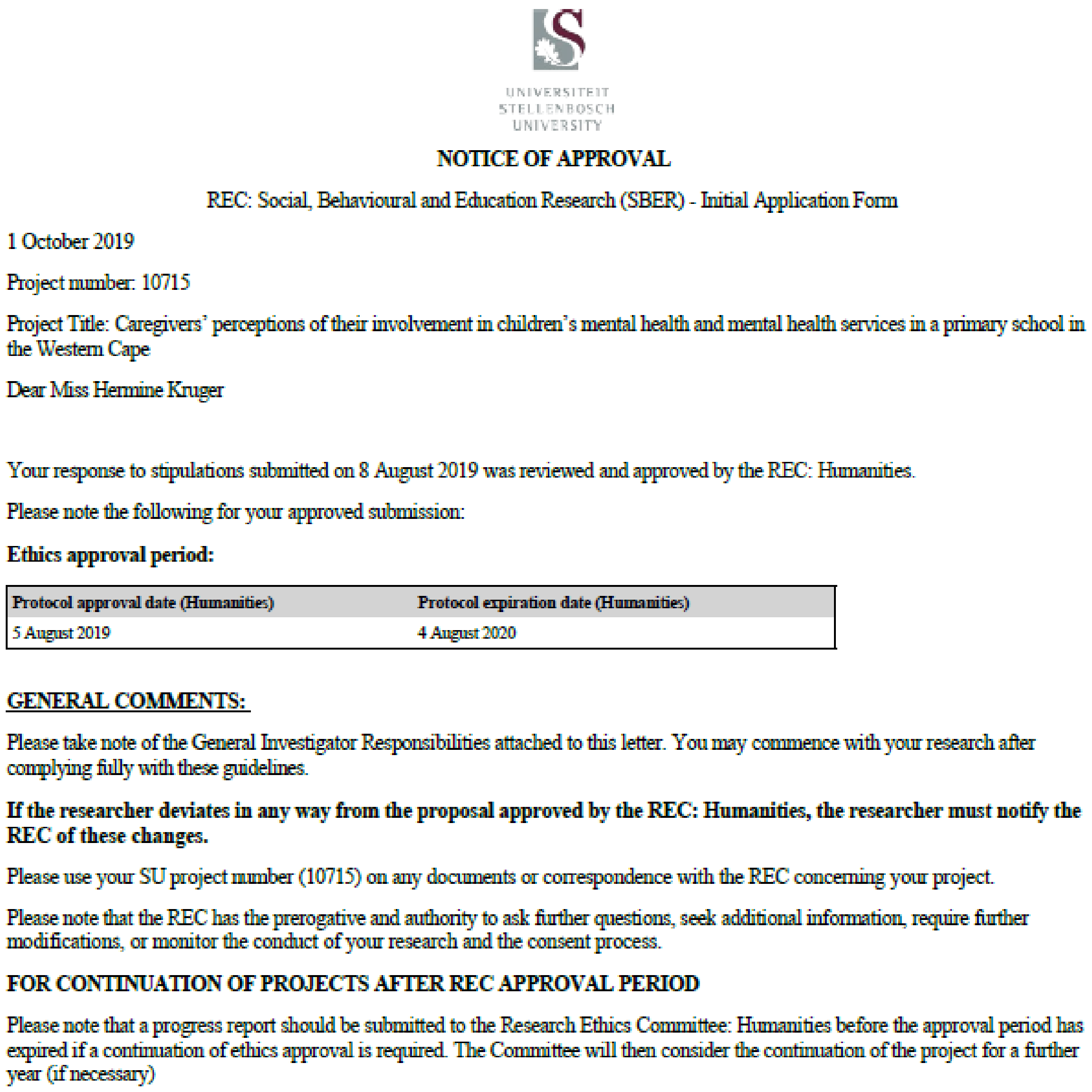
We wish you success in your research.

Kind regards.
Signed: Dr Audrey T Wyngaard
Directorate: Research
DATE: 05 July 2019

Lower Parliament Street, Cape Town, 8001
tel: +27 21 467 9272 fax: 0865902282
Safe Schools: 0800 45 46 47

Private Bag X9114, Cape Town, 8000
Employment and salary enquiries: 0861 92 33 22
www.westerncape.gov.za

Appendix C: Notice of approval by REC:SBER



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NOTICE OF APPROVAL

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

1 October 2019

Project number: 10715

Project Title: Caregivers' perceptions of their involvement in children's mental health and mental health services in a primary school in the Western Cape

Dear Miss Hermine Kruger

Your response to stipulations submitted on 8 August 2019 was reviewed and approved by the REC: Humanities.

Please note the following for your approved submission:

Ethics approval period:

Protocol approval date (Humanities)	Protocol expiration date (Humanities)
5 August 2019	4 August 2020

GENERAL COMMENTS:

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: Humanities, the researcher must notify the REC of these changes.

Please use your SU project number (10715) 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.

FOR CONTINUATION OF PROJECTS AFTER REC APPROVAL PERIOD

Please note that a progress report should be submitted to the Research Ethics Committee: Humanities 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)

Appendix D: Recruitment materials (Afrikaans)

Opsoek na Deelnemers vir 'n Navorsingstudie

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Sielkunde Department, Universiteit Stellenbosch

Navorsers: Hermine Kruger en Dr Bronwyne Coetzee

Doel van die navorsingstudie

Navorsing het al gewys dat skool-gebaseerde programme wat kinders help om hulle geestesgesondheidsprobleme te ondersteun, baie effektief is. Die sukses van sulke programme word dikwels deur die betrokkenheid van versorgers (soos ouers, familielede, en voogde) beïnvloed. Ons wil graag van jou leer:

*Hoe jy geestesgesondheid en geestesgesondheidsdienste verstaan

*Hoe jy oor geestesgesonheidsprobleme dink en geestesgesondheidsprobleme wat jy en jou kind ervaar, hanteer.

*Wat jy dink dit vir jou maklik of moeilik maak om van geestesgesondheidsdienste gebruik te maak.

* Wat jy dink jou rol in jou kind se geestesgesondheid en geestesgesondheidsdienste is.

Hierdie studie is deur die Navorsingsetiekkomitee: Sosiale, Gedrag, en Opvoedkunde Navorsing goedgekeur.

Wat sal van my verwag word?

Jy sal genooi word vir 'n in-persoon onderhoud met Hermine Kruger. Die onderhoud sal vir 45 - 60 min duur en in 'n private kamer in [redacted] Laerskool plaasvind. Ons sal 'n datum en tyd reël wat jou sal pas.

Wie kan deelneem?

*Ouer as 18 jaar.

*Primêre versorger (ouer, familielied, of voog) van tenminste een kind in graad 5-7

*Vlot in Afrikaans en/of Engels

Wat is die voordele van my deelname?

Jou insette kan toekomstige intervensies en dienste help om kinders die ondersteuning te bied wat hulle nodig het.

Wat is die risikos van my deelname?

Om oor sulke sensitiewe onderwerpre te gesels kan 'n bietjie ongemak of stres veroorsaak. Daar is prosedures in plek om jou te help indien jy dit sou wou hê of sou nodig kry.

Hoe neem ek deel?

Indien jy geïnteresseerd is om deel te neem, asseblief vul in en teken die kontak toestemmingsvorm. Stuur dan die vorm terug skool toe saam met jou kind. Die vorm moet by jou kind se LO opvoeder teen hulle volgende LO periode ingehandig word. 'n Navorser sal jou dan kontak om 'n datum en tyd vir 'n onderhoud op te stel.

Enige vrae?

Indien jy enige vrae het, asseblief kontak:

Hermine Kruger: 081 011 01 07

17534305@sun.ac.za

Kontak toestemmingsbrief

Titel van die studie: Die persepsies van versorgers oor hulle betrokkenheid in hulle kinders se geestesgesondheid en geestesgesondheidsdienste in 'n laerskool in die Weskaap.

Ek, ... (volle naam en van), wil graag meer leer oor hierdie studie wat oor my betrokkenheid by my kind se geestesgesondheid en geestesgesondheidsdienste gaan.

Hierdeur gee ek toestemming aan die navorser om my te kontak en die studie aan my te verduidelik. Ek mag met die volgende inligting gekontak word:

Telefoonnommer:	
Selfoonnommer:	
E-pos adres:	

Ek verkies om gekontak te word in:

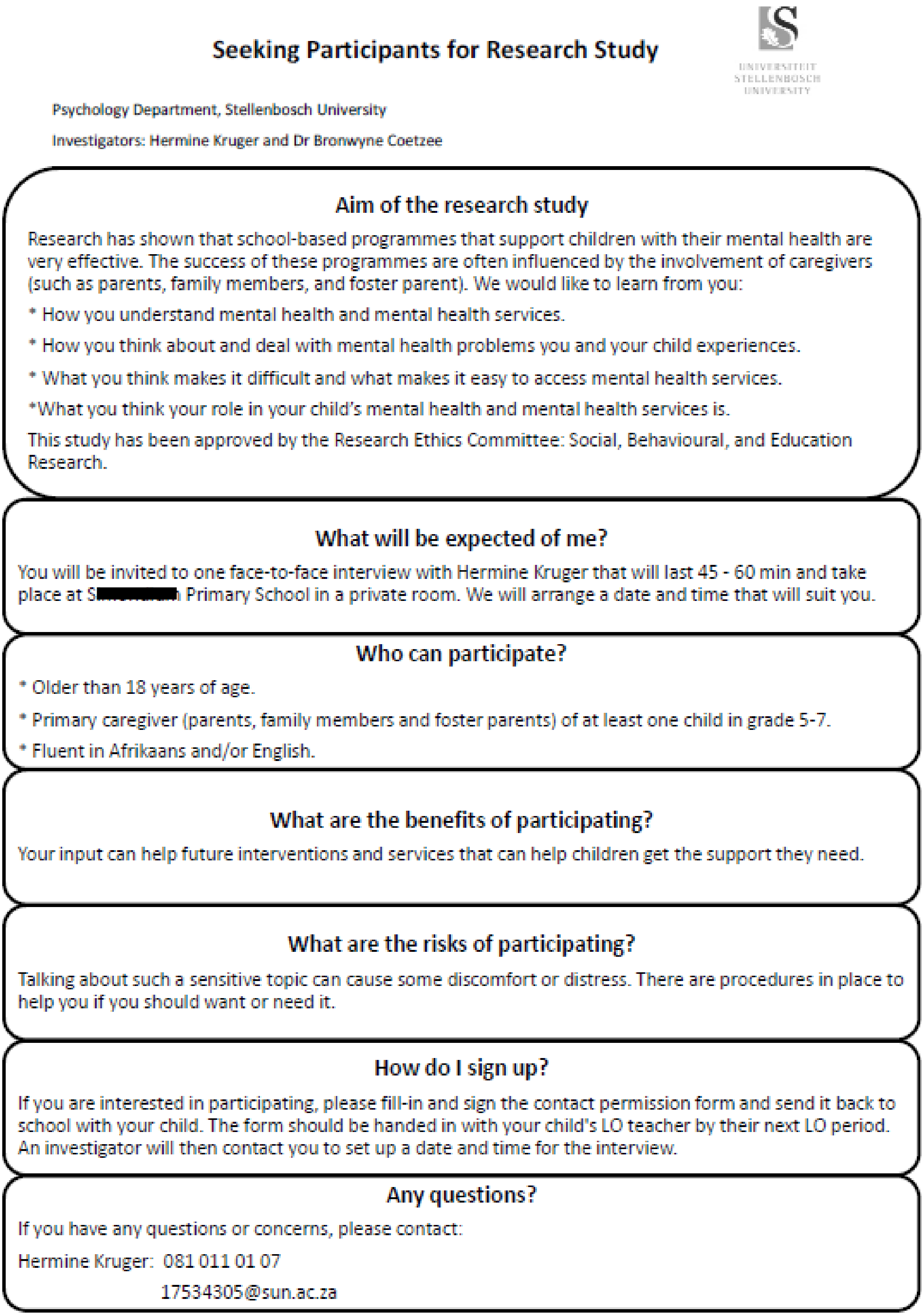
Afrikaans ☐

Engels ☐

Ek verstaan dat deur toestemming te gee om gekontak te word, ek nie aan die studie hoef deel te neem nie.

Handtekening: .... Datum: ....

Appendix D: Recruitment materials (English)



Seeking Participants for Research Study

Psychology Department, Stellenbosch University

Investigators: Hermine Kruger and Dr Bronwyne Coetzee

Aim of the research study

Research has shown that school-based programmes that support children with their mental health are very effective. The success of these programmes are often influenced by the involvement of caregivers (such as parents, family members, and foster parent). We would like to learn from you:

* How you understand mental health and mental health services.

* How you think about and deal with mental health problems you and your child experiences.

* What you think makes it difficult and what makes it easy to access mental health services.

*What you think your role in your child’s mental health and mental health services is.

This study has been approved by the Research Ethics Committee: Social, Behavioural, and Education Research.

What will be expected of me?

You will be invited to one face-to-face interview with Hermine Kruger that will last 45 - 60 min and take place at [redacted] Primary School in a private room. We will arrange a date and time that will suit you.

Who can participate?

* Older than 18 years of age.

* Primary caregiver (parents, family members and foster parents) of at least one child in grade 5-7.

* Fluent in Afrikaans and/or English.

What are the benefits of participating?

Your input can help future interventions and services that can help children get the support they need.

What are the risks of participating?

Talking about such a sensitive topic can cause some discomfort or distress. There are procedures in place to help you if you should want or need it.

How do I sign up?

If you are interested in participating, please fill-in and sign the contact permission form and send it back to school with your child. The form should be handed in with your child's LO teacher by their next LO period. An investigator will then contact you to set up a date and time for the interview.

Any questions?

If you have any questions or concerns, please contact:

Hermine Kruger: 081 011 01 07
17534305@sun.ac.za

Contact Permission Form

Title of the research study: The involvement of caregivers in children's mental health and mental health services in a primary school in the Western Cape.

I, ……………………………………………………………………………………… (full name and surname), would like to learn more about this study about my involvement in children's mental health and mental health services.

I hereby give permission for the investigators to contact me and explain this study to me. I may be contacted by the following details:

Telephone number	
Cell phone number	
Email	

I prefer to be in contacted in:

Afrikaans ☐

English ☐

I understand that giving permission to be contacted, I don't have to participate in this study.

Signature: …………………………………………………………… Date: ……………………………………………………………

Appendix E: Consent form (Afrikaans)

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UNIVERSITEIT STELLENBOSCH

TOESTEMMING OM AAN NAVORSING DEEL TE NEEM

Titel: Versorgers se persepsies oor hulle betrokkenheid in kinders se geestesgesondheid en geestesgesondheidsdienste in 'n laerskool in die Wes-Kaap.

Die studie word uitgevoer deur Me Hermine Kruger en Dr Bronwynè Coetzee, van die Sielkunde Departement aan die Universiteit van Stellenbosch.

Jy word as 'n moontlike deelnemer genader omdat jy die primêre versorger is van 'n kind in graad 5-7 (ouderdom 11-14), wie laerskool bywoon. Dit beteken dat jy 'n ouer, familielid, of voog van 'n kind is en jy die grootste verantwoordelik dra vir die daaglikse versorging van daardie kind. Ons nader jou ook omdat jy ouer as 18 jaar oud is en Afrikaans en/of Engels vlot kan praat.

1. DOEL VAN DIE STUDIE

Navorsing het gewys dat skool-gebaseerde programme en -dienste, wat kinders se geestesgesondheid ondersteun, baie effektief is. Die sukses van hierdie programme word dikwels deur die betrokkenheid van versorgers beïnvloed. Om dit beter te verstaan, wil ons graag jou betrokkenheid, as 'n versorger, in jou kind se geestesgesondheid en geestesgesondheidsdienste ondersoek en verstaan.

Ons will graag by jou leer:

- Hoe jy geestesgesondheid en geestesgesondheidsdienste verstaan.
- Hoe jy oor geestesgesondheidsprobleme dink en geestesgesondheidsprobleme wat jy en jou kind(ers) ervaar, hanteer.
- Wat jy dink dit moeilik maak en wat jy dink dit maklik maak vir jou om toegang tot geestesgesondheidsdienste te verkry.
- Wat jy dink jou rol in jou kind(ers) se geestesgesondheid en geestesgesondheidsdienste is.

Deur met jou oor hierdie dinge te gesels, kan ons beter verstaan hoe versorgers by hulle kinders se geestesgesondheid en geestesgesondheidsdienste betrokke is. Met hierdie inligting kan ons skool-gebaseerde programme en -dienste, wat kinders se geestesgesondheid ondersteun, verbeter. Hierdie studie is deur die Navorsingsetiekkomitee: Sosiale, Gedrag, Opvoedkunde Navorsing goedgekeur.

2. WAT SAL VAN MY VERWAG WORD?

Indien jy instem om aan hierdie studie deel te neem, sal van jou verwag word om:

- Aan een onderhoud met Hermine Kruger in 'n privaat kamer by [redacted] Laerskool deel te neem. Die onderhoud sal tussen 45-60 minute duur en sal plaasvind op 'n datum en tyd, wat jou pas. Jy kan kies of die onderhoud in Afrikaans en/of Engels uitgevoer moet word. Met jou toestemming sal die onderhoud op 'n band opgeneem word.
- 'n Vraelys in te vul wat persoonlike inligting gaan vra oor jou: Ouderdom, huistaal, opleiding, indiensneming, jou verhouding met jou kind, hoeveel tyd jy met jou kind spandeer, en gedurende watter aktiwiteite jy die meeste tyd met jou kind spandeer. Ons vra hierdie vrae sodat ons die groep versorgers met wie ons gesels het, kan beskryf. Ons sal nie jou naam of van op enige van die vorms aanteken nie.
- Vrae wat aan die navorsingsonderwerp verwant is, te beantwoord. Ons wil graag hê dat jy die vrae openlik en eerlik beantwoord. Indien jy nie 'n vraag wil beantwoord nie, kan jy my laat weet en dan sal ons na die volgende vraag toe aanbeweeg, sonder enige nagevolge.

3. MOONTLIKE RISIKO'S EN ONGEMAKLIKHEDE

Ons voorsien nie dat jou deelname aan hierdie studie enige risiko's vir jou inhou nie. Sommige van die onderwerpe waaroor ons gaan gesels kan egter van 'n sensitiewe aard en privaat wees en mag ongemaklikheid of ligte ontsteltenis veroorsaak. Indien jy enige ontsteltenis ervaar as gevolg van jou deelname aan hierdie studie en emosionele ondersteuning nodig sou hê, sal ek jou na 'n berader by [redacted] verwys. [redacted] is bewus van die studie en het ingestem om een gratis sessie aan elke deelnemer, wat ondersteuning nodig sou hê, te verskaf.

4. MOONTLIKE VOORDELE VIR DIE DEELNEMER/GEMEENSKAP

Ons voorsien nie dat jou deelname aan hierdie studie enige direkte voordele vir jou sal inhou nie. Om oor sommige van hierdie onderwerpe te gesels, kan egter terapeutiese voordele inhou. Die belangrikste voordeel van jou deelname aan hierdie studie, is die waardevolle inligting en insig wat ons by jou gaan opdoen. In die toekoms kan hierdie inligting ander mense help om geestesgesondheidsdienste en -programme, tot voordeel van kinders se geestesgesondheid, te verbeter.

5. BETALING VIR DEELNAME

Daar sal geen betaling of vergoeding wees vir jou deelname aan hierdie studie nie. Dit sal jou egter ook niks kos om aan hierdie studie deel te neem nie. Ons gaan probeer om die onderhoud rondom 'n tyd te skeduleer wat jy alreeds na die skool toe reis, soos byvoorbeeld wanneer jy jou kind aflaai of optel by die skool. Indien dit nodig sou wees vir jou om 'n onderhoud op 'n ander tyd by te woon, sal ons jou vir jou reiskostes vergoed.

6. BESKERMING VAN JOU INLIGTING, VETROULIKHEID EN IDENTITEIT

Alle inligting wat jy met my gedurende die studie deel en jou moontlik as 'n deelnemer kan identifiseer, sal beskerm word. Dit sal gedoen word deur seker te maak dat alle inligting wat ons van jou versamel anoniem gemaak sal word. Dit beteken dat jou naam en van nie op enige van die vorms aangeteken sal word nie, sodat geen van die inligting aan jou verbind kan word nie.

Ons sal verseker dat alle inligting wat ons van jou gaan versamel, ten alle tye met vertroulikheid hanteer sal word. Dit beteken dat net die navorsers, Me Hermine Kruger en Dr Bronwynè Coetzee, toegang tot jou inligting sal hê. Ons sal vertroulikheid verseker deur die inligting wat ons van jou versamel, veilig te stoor. Alle digitale inligting, soos bandopnames, transkripsies, nota's, analises en opskrywings, sal as 'n versleutelde lêer op die wagwoordbeskermde rekenaars van die navorsers gestoor word. Alle papier-gebaseerde dokumente, soos die toestemmingsbrief, demografiese vorm, nota's en joernale sal in 'n kas in Dr Coetzee se kantoor op die Universiteit se perseel geliasseer en toegesluit word.

Ons wil graag 'n bandopname van die onderhoud maak om te verseker dat ons jou antwoorde op die vrae reg insamel. Die bandopname gaan dan woord vir woord deur Me Hermine Kruger en Dr Bronwynè Coetzee getranskribeer (oorgeskryf) word. Die inligting wat ons van jou versamel het, gaan dan geanaliseer word en vir die doel van 'n tesis vir 'n meestersgraad en vir 'n moontlike joernaalartikel gebruik word. Geen van die inligting wat ons insamel en oor gaan skryf sal na jou toe herlei kan word nie. Die enigste inligting wat ons sal gebruik om die versorgers met wie ons gesels het, te beskryf, is die demografiese inligting wat jy aan ons sal verskaf.

7. DEELNAME EN ONTREKKING

Jy kan kies om aan hierdie studie deel te neem of nie. Indien jy instem om aan hierdie studie deel te neem, mag jy enige tyd onttrek sonder enige nagevolge. As jou inligting egter anoniem gemaak is, gegroepeer is met ander data, en ons alreeds met analise begin het, gaan ons nie meer jou inligting kan onttrek nie. Indien jy egter, voordat analise plaasvind, besluit om van hierdie studie te onttrek, sal alle elektroniese inligting en papier-gebaseerde data (soos bo beskryf) wat ons van jou versamel het, vernietig word. Dit beteken dat ons alle elektroniese data op alle hardeware permanent sal uitwis en alle papier-gebaseerde dokumente sal snipper en veilig weggooi. Jy mag ook weier om enige vrae, wat jy nie wil antwoord nie, te antwoord en nogsteeds aan die studie deelneem. Die navorsers mag jou van die studie onttrek as hulle voel dat jy te ontsteld is om met die onderhoud aan te hou, jy glad nie aan die onderhoud deel neem nie, of as jy nie aan die kriteria vir deelname voldoen nie.

8. NAVORSERS SE KONTAKBESONDERHEDE

Indien jy enige vrae of bekommernisse oor hierdie studie het, staan dit jou vry om ons by die volgende besonderhede te kontak: Me Hermine Kruger [**e-posadres:** hmkruger@sun.ac.za **telefoonnommer:** 081 011 0107] en Dr Bronwynè Coetzee [**e-posadres:** bronwyne@sun.ac.za **telefoonnommer:** 021 808 3979].

9. REGTE VAN NAVORSINGSDEELNEMER

Jy mag jou toestemming enige tyd onttrek en jou deelname staak sonder enige straf. Deur deel te neem aan hierdie navorsingstudie doen jy geensins afstand van enige wetlike regte, eise of regsmiddel nie. Indien jy enige vrae het oor jou regte as navorsingsdeelnemer kontak Mej Maléne Fouché [mfouche@sun.ac.za; 021 808 4622] by die Afdeling van Navorsingsontwikkeling.

VERKLARING VAN TOESTEMMING DEUR DIE DEELNEMER

As 'n deelnemer verklaar ek dat:

- ek die bostaande inligting gelees het en dat dit in 'n taal geskryf is waarmee ek gemaklik is.
- ek 'n kans gehad het om vrae te vra en al my vrae beantwoord is.
- ek verstaan dat my deelname vrywillig is en dat ek enige tyd van die studie mag onttrek sonder enige negatiewe nagevolge.
- ek verstaan dat daar geen potensiële risiko's of direkte voordele vir my deelname aan hierdie studie is nie.
- alle kwessies rakende privaatheid en die vetroulikheid en gebruik van die inligting wat ek verskaf, aan my verduidelik is.

Ek stem in dat die onderhoud op 'n tyd en plek, wat vir my gerieflik is (wat my pas), plaasgevind het:
☐ Ja
☐ Nee

Ek stem in dat nie vir my nodig was om verlof of afwesigheid van die werk te neem om aan hierdie studie deel te neem nie:

☐ Ja
☐ Nee
☐ Nie van toepassing nie

Deur hier onder te teken, stem ek, ________________________________ *(naam van deelnemer)* in om aan hierdie studie deel te neem, wat deur ____________________ *(naam van hoofnavorser)* uitgevoer word.

____ ______________________

Handtekening van deelnemer **Datum**

VERKLARING DEUR DIE HOOFNAVORSER

As die **hoofnavorser** verklaar ek hierdeur dat die inligting in hierdie dokument deeglik aan die deelnemer verduidelik is. Ek verklaar ook dat die deelnemer aangemoedig is (en genoeg tyd gebied is) om enige vrae te vra. Daarbenewens wil ek graag die volgende opsie kies:

	Die gesprek met die deelnemer gevoer is in 'n taal waarin die deelnemer vlot (magtig) is.
	Die gesprek met die deelnemer gevoer is met behulp van 'n tolk [wie 'n verswygingsooreenkoms (ooreenkoms van nie-openbaarmaking) onderteken het] en hierdie "Toestemmingsvorm" is beskikbaar aan die deelnemer in 'n taal waarin die deelnemer vlot (magtig) is.

____ ______________________

Handtekening van die hoofnavorser **Datum**

Appendix E: Consent form (English)

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jou kennisvennoot • your knowledge partner

STELLENBOSCH UNIVERSITY

CONSENT TO PARTICIPATE IN RESEARCH

Title: Caregiver's perceptions of their involvement in Children's Mental Health and Mental Health Services in a Primary School in the Western Cape.

This study is being conducted by Me Hermine Kruger and Dr Bronwyne Coetzee, from the Psychology Department at Stellenbosch University.

You have been approached as a possible participant because you are the primary caregiver of a child in grade 5-7 (ages 11-14) attending primary school. That means that you are either a parent, a family member, or a foster parent who has the greatest responsibility for the daily care of the child. We are also approaching you as a possible participant because you are older than 18 years of age, and speak Afrikaans and/or English fluently.

1. PURPOSE OF THE STUDY

Research has shown that school-based programmes and services that support children with their mental health are very effective. The successes of these programmes and services are often influenced by the involvement of caregivers. To better understand this, we would like to explore and understand your involvement, as a caregiver, in your children's mental health and mental health services.

We would like to learn from you:

- How you understand mental health and mental health services.
- How you think about and deal with mental health problems you and your child experiences.
- What you think makes it difficult and what makes it easy to access mental health services.
- What you think your role in your child's mental health and mental health services is.

By talking to you about these things we can understand how caregivers are involved in the mental health and mental health services of their children. With this information we might be able to improve school-based programmes and services that support the mental health of children. This study has been approved by the Research a Committee: Social, Behavioural, and Education Research.

2. WHAT WILL BE ASKED OF ME?

If you agree to take part in this study, you will be asked to:

- Participate in one interview with Me Hermine Kruger in a private room at [redacted] Primary School. The interview will last between 45 and 60 minutes and will take place at a time and date that will suit you. You can choose whether the interview should be conducted in Afrikaans or English. With your permission, the interview will be audio-recorded.

- Fill in a questionnaire that collects personal information about your age, gender, home/first language, employment status, how many hours per day you spend with your child, your relationship to the child, and during which activity you spend the most time with your child. We ask this information so that we can describe the group of caregivers that we spoke to. We will not record your name or surname on any of these forms.
- Answer a few questions relating to the topic of the study. We would like you to answer the questions openly and honestly. If you do not want to answer a question, you can let me know and we can move on to the next question without any consequences.

3. POSSIBLE RISKS AND DISCOMFORTS

We do not see any risks of participating in this study. However, some of the topics we will talk about might be sensitive and of a private nature and might cause some discomfort or mild distress. If you experience any distress and require emotional support due to your participation in this study, I will refer you to a counsellor at [redacted]. [redacted] are aware of the study and have agreed to give one free session to every participant that should need the support.

4. POSSIBLE BENEFITS TO PARTICIPANTS AND/OR TO THE SOCIETY

We do not see any direct benefit of participating in this study. Talking through some of the topics in the interview might, however, hold some therapeutic advantages. The most important benefit of your participation is the valuable information and insight we will gain from you. In the future, this information might help others to improve mental health services and programmes to the benefit of the mental health of children.

5. PAYMENT FOR PARTICIPATION

There will be no payment or compensation for participating in this study. It will also not cost you anything to participate in this study. We will attempt to schedule the interviews around the time you would be travelling to school, i.e. dropping off or picking up your child. If it should be required that you attend an interview at another time, we will reimburse your travelling costs. You will receive light refreshments during the interview.

6. PROTECTION OF YOUR INFORMATION, CONFIDENTIALITY AND IDENTITY

Any information you share with me during this study and that could possibly identify you as a participant will be protected. This will be done by making sure that all the information that we collect from you will be anonymised. This means that your name and surname will not be recorded on any forms so none of the information can be linked back to you.

We will also make sure that all the information we collect from you will be treated with confidentiality at all times. This means that we will make sure that only the investigators, Me Hermine Kruger and Dr Bronwyne Coetzee, will have access to your information. We will ensure the confidentiality of your information by safely storing all the information we collect from you. All digital information, such as the recording, transcripts, notes, analyses, and write-ups will be stored as an encrypted file on the password protected computers of the investigators. No data will be shared via or stored on an external devices. All paper-based documents, like the consent form, demographic form, notes, and journals will be filed and stored in a locked cabinet in Dr Coetzee's office on university property. All data will be backed-up in a OneDrive folder that only the investigators will have access to.

We would like to audio-record the interview with you to make sure we correctly capture your responses to our questions. The audio-recording will immediately be transferred to a password-protected computer and removed from the recording device following the interview. The audio-recording will then be transcribed word-for-word by the Me Hermine Kruger and Dr Bronwyne Coetzee. The information we gather from you will then be analysed and used for the purposes of a master's degree thesis as well as a possible journal article. None of the information we gather and will write about will be able to be linked back to you. The only information we will use to describe the caregivers we talked to will be the demographic information you provided us with.

7. PARTICIPATION AND WITHDRAWAL

You can choose whether to be in this study or not. If you agree to take part in this study, you may withdraw at any time without any consequence. However, once your information has been anonymised and grouped with other data that we have collected and we have begun to analyse this data, we will no longer be able to withdraw your information. If you decide to withdraw from the study, before we start with analysis, all electronic and paper-based data (as described above) collected from you will be destroyed. This means that we will permanently delete all electronic data from all hard drives and shred and safely discard all paper-based documents. You may also refuse to answer any questions you don't want to answer and still remain in the study. The researcher may withdraw you from this study if they feel that you are too distressed to continue the interview, do not participate in the interview at all, or if you do not meet the criteria for participation.

8. RESEARCHERS' CONTACT INFORMATION

If you have any questions or concerns about this study, please feel free to contact Me Hermine Kruger [e: hmkruger@sun.ac.za t: 0810110107] and/or the supervisor Dr Bronwyne Coetzee [e: bronwyne@sun.ac.za t: 021 808 3979].

9. RIGHTS OF RESEARCH PARTICIPANTS

You may withdraw your consent at any time and discontinue participation without penalty. You are not waiving any legal claims, rights or remedies because of your participation in this research study. If you have questions regarding your rights as a research participant, contact Ms Maléne Fouché [mfouche@sun.ac.za; 021 808 4622] at the Division for Research Development.

DECLARATION OF CONSENT BY THE PARTICIPANT

As the participant I confirm that:

- I have read the above information and it is written in a language that I am comfortable with.
- I have had a chance to ask questions and all my questions have been answered.
- I understand that my participation is voluntary and that I may withdraw from the study at any time without negative consequences.
- I understand that there is no potential risk or direct benefit in participating in this study.
- All issues related to privacy, and the confidentiality and use of the information I provide, have been explained.

I agree that the interview took place at a time and place that is convenient to me.

☐ Yes

☐ No

I agree that it was not necessary for me to take a leave of absence from work to participate in this study.

☐ Yes

☐ No

☐ Not applicable

By signing below, I ________________________________ *(name of participant)* agree to take part in this research study, as conducted by ______________________ *(name of principal investigator)*.

_______________________________________ ______________________

Signature of Participant **Date**

DECLARATION BY THE PRINCIPAL INVESTIGATOR

As the **principal investigator,** I hereby declare that the information contained in this document has been thoroughly explained to the participant. I also declare that the participant has been encouraged (and has been given ample time) to ask any questions. In addition I would like to select the following option:

	The conversation with the participant was conducted in a language in which the participant is fluent.
	The conversation with the participant was conducted with the assistance of a translator (who has signed a non-disclosure agreement), and this "Consent Form" is available to the participant in a language in which the participant is fluent.

_______________________________________ ______________________

Signature of Principal Investigator **Date**

Appendix F: Demographic form (Afrikaans)

Demografiese vorm

Deelnemerskode: ____________________

Datum van onderhoud: ____________________

Tyd van onderhoud: ____________________

---

1. **Wat is jou huidige ouderdom?** ____

2. **Wat is jou geslag?** Vroulik☐ Manlik ☐ Ander☐

3. **Wat is jou huistaal?**

   Afrikaans ☐ Engels ☐ Xhosa ☐ Zulu ☐ Ander☐ _____________

4. **Wat is jou hoogste vlak van opvoeding?**

   Laerskool ☐ Graad 9 ☐ Graad 12 ☐ Tertiêr ☐ Ander ☐____________

5. **Wat is jou huidige indiensnemingstatus?**

   Voltyds ☐ Deeltyds ☐ Werkloos ☐

6. **Wat is jou verhouding tot die kind?**

   Biologiese ouer ☐ Familielid ☐ Voog ouer ☐ Ander ☐________

7. **Hoeveel ure 'n dag (gemiddeld) spandeer jy met jou kind?**

   < 1 ure ☐ 1-5 ure ☐ > 5 ure ☐

   Gedurende watter aktwiteit spandeer jy en jou kind die meeste tyd saam?

   ____

Appendix F: Demographic form (English)

Demographic Form

Participant code: ____________________

Date of interview: ____________________

Time of interview: ____________________

---

1. What is your current age? ____

2. What is your gender? Female ☐ Male ☐ Other ☐

3. What is your home language?

Afrikaans ☐ English ☐ Xhosa ☐ Zulu ☐ Other ☐ ______________

4. What is your highest level of education?

Primary school ☐ Grade 9 ☐ Grade 12 ☐ Tertiary ☐ Other ☐_____________

5. What is your current employment status?

Full-time ☐ Part-time ☐ Unemployed ☐

6. What is your relationship to the child?

Biological parent ☐ Family member ☐ Foster parent ☐ Other ☐________

7. How many hours a day do you spend with the child?

< 1 hour ☐ 1-5 hours ☐ > 5 hours ☐

8. During which activity do you spend the most time with your child?

____

Appendix G: Interview schedule (Afrikaans)

Onderhoudskedule

Deelnemerskode: ________________

Datum van onderhoud: ________________

Tyd: ________________

Onderhoudvoerder: Dankie dat jy ingestem het om aan hierdie studie deel te neem. Nou dat ons deur die toestemmingsbrief gelees het en dit geteken het, as jy aan iemand moes verduidelik waaroor hierdie studie gaan, wat sou jy vir hulle vertel? Hierdie is nie 'n toets nie so daar is geen regte of verkeerde antwoord nie. Ons wil graag weet of die toestemmingsbrief werk en of ons nodig het om dit aan te pas om dit duideliker te maak.

Deelnemer: ________

Onderhoudvoerder: Dankie. Soos jy weet, ons probeer om te verstaan hoe versorgers by hulle kinders se geestesgesondheid en geestesgesondheidsdienste betrokke is. Ek wil graag vir jou 'n paar vrae vra. Weereens, hierdie vrae is nie 'n toets nie so daar is geen regte of verkeerde antwoord nie. Jy is die kenner en ek wil na jou luister en by jou leer. Dit is belangrik dat jy hierdie vrae so openlik en eerlik as moontlik beantwoord, maar as daar enige vrae is wat jy nie wil beantwoord nie, asseblief sê my dan sal ons na die volgende vraag toe anbeweeg.

1. Inleidingsvraag:
   1.1 Hoekom het jy besluit om aan hierdie studie deel te neem?
2. Bestuur van geestesgesondheid:
   2.1 Versorger:
      2.1.1 Wanneer jy bekommerd (angstig/ emosioneel) voel oor iets, hoe hanteer jy dit gewoonlik?
      2.1.2 Dink jy jou kind weet wanneer jy bekommerd (angstig/ emosioneel) voel oor iets?
      2.1.3 Hoe dink jy affekteer dit jou kind?
      2.1.4 Wat dink jy kan jou help om sulke probleme beter te hanteer?
   2.2 Kind:
      2.2.1 Watter tipe probleme praat jou kind gewoonlik met jou oor?
      2.2.2 Hoe hanteer jou kind dit gewoonlik?

2.2.3 Hoe hanteer jy dit gewoonlik?

2.2.4 Hoe dink jy affekteer hierdie probleme jou kind?

2.2.5 Wat dink jy kan jou kind help of sulke probleme beter te hanteer?

3. <u>Hindernisse en fasiliteerders tot geestesgesondheidsdienste</u>

3.1 Weet jy of jou kind al van geestesgesondheidsdienste (soos sielkundige dienste/ skoolberader/ [redacted]s) gebruik gemaak het?

Nee hulle het nie:

3.2 Hoekom nie?

3.3 As jou kind 'n geestesgesondheidsprobleem sou ervaar, dink jy julle/hy/sy sal van geestesgesondheidsdienste (soos sielkundige dienste/ skoolberader/ [redacted] [redacted]) gebruik maak?

3.3.1 Hoekom / Hoekom nie?

3.4 Hoe sal jy omgaan om gebruik te maak van geestesgesondheidsdienste?

3.5 Wat dink jy sal dit vir jou moeilik maak vir jou en jou kind om van geestesgesondheidsdienste gebruik te maak?

3.6 Wat dink jy sal dit vir jou maklik maak vir jou en jou kind om van geestesgesondheidsdienste gebruik te maak?

Ja hulle het:

3.7 Hoekom?

3.8 Hoe het jy omgegaan om gebruik te maak van geestesgesondheidsdienste?

3.9 Wat dink jy het dit vir jou en jou kind moeilik gemaak om van geestesgesondheidsdienste gebruik te maak?

3.10 Wat dink jy het dit vir jou en jou kind maklik gemaak om van geestesgesondheidsdienste gebruik te maak?

<u>Rol van versorger</u>

3.11 Wat dink jy is jou rol in jou kind se geestesgesondheid?

3.12 Dink jy ouers/versorgers moet betrokke wees by hulle kinders se geestesgesondheid?

3.13 Dink jy ouers/versorgers moet betrokke wees by die behandeling van hulle kinders se geestesgesondheidsprobleme?

3.13.1 Hoekom / Hoekom nie?

3.13.2 Hoe moet hulle betrokke wees?

3.13.3 Hoe kan ons ouers/versorgers meer/minder betrokke maak?

4. <u>Konsepsualisering van geestesgesondheid en geestesgesondheidsdienste</u>
    - 4.1 Wat beteken die term "geestesgesondheid" vir jou?
    - 4.2 Wat beteken die term "geestesgesondheidsprobleme" vir jou?
    - 4.3 Wat beteken die term "geestesgesondheidsdienste" vir jou?
    - 4.4 Dink jy dit beteken dieselfde vir kinders?
5. <u>Afsluitende vrae:</u>
    - 5.1 Hoe voel jy oor die vrae wat ek jou gevra het?
    - 5.2 Is daar enige iets wat jy voel jy wil bysit?
    - 5.3 Het jy vir my enige vrae?

Afluiting: Hierdie is nou die einde van ons onderhoud. Ek wil vir jou weer dankie sê vir jou tyd en bereidwilligheid om aan hierdie studie deel te neem. Dankie vir jou storie en jou insig, ek het baie van jou geleer en jou storie gaan baie vir hierdie studie beteken.

Appendix G: Interview schedule (English)

Interview Schedule

Participant Code: ________________
Date of interview: ________________
Time: ________________

Interviewer: Thank you for agreeing to participate in this study. Now that we have read through and signed the consent form, if you had to explain to someone what this study is about, what would you tell them? This is not a test so there is no right or wrong answer; we just want to know if the consent form works and whether we need to adjust it to make it clearer.

Participant: ________

Interviewer: Thank you. So as you know, we are trying to understand how caregivers are involved in children's mental health and mental health services. I would like to ask you a few questions. Again, these questions are not a test so there is no right or wrong answer. You are the expert and I want to listen to you and learn from you. It is important that you answer these questions as openly and honestly as possible, but if there any of the questions that you don't want to answer, please tell me and we will move on to the next question.

1. Introductory questions:
   1.1 Why did you decide to participate in this study?
2. Management of mental health
   2.1 Parent:
      2.1.1 When you are feeling worried (anxious/ emotional /concerned) about something, how do you usually deal with it?
      2.1.2 Do you think your child knows when you are worried (anxious/ emotional / concerned) about something?
      2.1.3 How do you think it affects your child?
      2.1.4 What do you think could help you deal with such problems better?
   2.2 Child:
      2.2.1 What kind of problems does your child usually talk to you about?
      2.2.2 How does your child usually deal with it?
      2.2.3 How do you usually deal with it?

   - 2.2.4 How do you think these problems affect your child?
   - 2.2.5 What do you think could help your child deal with such problems better?

3. Barriers and facilitators to mental health services
   - 3.1 Do you know if your child has ever made use of mental health services (psychological services/ school guidance counsellor/ [redacted])?

No they haven't:

   - 3.2 Why not?
   - 3.3 If your child were to experience a mental health problem, would they/you make use of mental health services (psychological services/ school guidance counsellors/ [redacted]?
      - 3.3.1 Why / why not?
   - 3.4 How would access these services?
   - 3.5 What do think would make it difficult for you and your child to access these services?
   - 3.6 What do you think would make it easy for you and your child to access these services?

Yes they have:

   - 3.7 Why?
   - 3.8 How did you access these services?
   - 3.9 What made it difficult for you and your child to access these services?
   - 3.10 What made it easy for you and your child to access these services?

4. Role of caregiver
   - 4.1 What do you think is your role in your child's mental health?
   - 4.2 Do you think parents/caregivers should be involved in the mental health of children?
   - 4.3 Do you think parents/caregivers should be involved in the treatment of their children's mental health problems?
      - 4.3.1 Why/why not?
      - 4.3.2 How should they be involved?
      - 4.3.3 How can we get parents/caregivers to be more/less involved?

5. Conceptualisation of mental health and mental health services
   - 5.1 What does the term "mental health" mean to you?
   - 5.2 What does the term "mental health problems" mean to you?
   - 5.3 What does the term "mental health services" mean to you?
   - 5.4 Do you think this means the same for children?

6. Concluding questions:
    6.1 How do you feel about the questions I asked you?
    6.2 Is there anything you feel you want to add?
    6.3 Do you have any questions for me?

Concluding remarks: This is now the end of our interview. I would like to thank you again for your time and willingness to participate in this study. Thank you for your story and your insight, I have learnt a lot from you and your story is going to mean a lot for this study.

Appendix H: Interview Schedule and demographic measures of Wellcome Trust study (English)

Form-3 Interview schedule - parent

CODE					

DATE								
	d	d	m	m	y	y	y	y

Interviewer Name: ______________________

Start time: ______________________

End time: ______________________

Thank you for agreeing to take part in this study.

I want to assure you that this is not a test or an evaluation, there is no right or wrong answer. We want to learn from you. However, most of us feel nervous before an interview.

How did you feel while you were on your way to this appointment today?

Before we start the interview, will you please tell me, in your own words, what this study is about?

I would now like to ask you a few questions. Again, this is not a test or an evaluation, there is no right or wrong answer. We want to learn from you. If you do not feel comfortable answering a particular question, you can just let me know and we can move onto the next question.

1. Why did you decide to take part in this study?

2. What does the words **"mental health"** mean to you?
    - Probe: How would you explain the words "mental health" to … Child of Interest (COI)?

   What does the words **"psychological health"** mean to you?
    - Probe: How would you explain the words "psychological health" to … (COI)?

   What does the words **"emotional health"** mean to you?
    - Probe: How would you explain the words "emotional health" to … (COI)?

What does the words **“mental health problems”** mean to you?

- Probe: How would you explain the words “mental health problems” to … (COI)?

What does the words **“psychological problems”** mean to you?

- Probe: How would you explain the words “psychological health” to … (COI)?

What does the words **“emotional problems”** mean to you?

- Probe: How would you explain the words “emotional problems” to … (COI)?

3. What do you, as a family, do when someone in your family has **mental health problems**?
   - Probe: What do you, as a family, do when … (COI) has mental health problems?”

   … And when someone in your family has **psychological problems**?
   - Probe: What do you, as a family, do when … (COI) has psychological problems?”

   … And when someone in your family has **emotional problems**?
   - Probe: What do you, as a family, do when … (COI) has emotional problems?”

   - Probe: What do you, as a family, do when someone in your family feels **sad**?
     … When … (COI) feels sad?

     … And when someone in your family feels **angry**?
     … When … (COI) feels angry?

     … And when someone in your family feels **scared**?
     … When … (COI) feels scared?

   - Probe: Do you and your child’s mother / father behave in the same way? Or do the two of you behave differently?

4. In what ways are you involved in the school?
   - Probe:
     Do you want to be involved?
     Do you like being involved?
     Can you tell me about ways that you would like to be more involved?

5. If we were to develop a program that helped children with emotional problems, that helped children to explore their negative / bad feelings and negative / bad thoughts and taught them ways to cope, do you think it would be helpful?
    - Probe: What things should we focus the most on?
      Should we focus mostly on negative / bad **feelings**?
      Should we focus mostly on negative / bad **thoughts**?
      Should we focus mostly on negative / bad **behaviours**?
      Why?

    - Probe: What kind of activities would you suggest that we use in the program to involve children, to get children interested in taking part in the program?

6. We are thinking about implementing the program with entire classrooms (for example with the Grade 5A, 5B, and 5C classes, etc.).
   Do you think that this is a good idea? Why / why not?
   Do you think that it will work? Why / why not?
   Your thoughts / ideas?

7. Would you be interested in being a part of such a program? Can you please explain why / why not?
    - Probe: What, in your opinion, would be the best way to involve parents?
    - Probe: Who else, do you think, would benefit from such a program?

8. Have you ever received counselling? Have you ever been to a psychologist?

Thank you.

Appendix H: Interview Schedule and demographic measures of Wellcome Trust study (Afrikaans)

Vorm-3 Onderhoudskedule – ouer

KODE					

DATUM								
	d	d	m	m	j	j	j	j

Onderhoudvoerder se naam: ______________________

Tyd – Begin: ______________________

Tyd – Einde: ______________________

Dankie dat jy toegestem (ingewillig) het om deel te neem aan hierdie studie.

Ek wil jou verseker dat hierdie nie 'n toets of 'n evaluasie is nie, daar is nie 'n regte of 'n verkeerde antwoord nie. Ons wil by jou leer. Die meeste van ons voel egter benoud voor 'n onderhoud.

Hoe het jy gevoel terwyl jy oppad was na hierdie afspraak toe vandag?

Voordat ons met die onderhoud begin, sal jy asseblief, in jou eie woorde, vir my vertel waaroor hierdie studie gaan?

Ek wil nou vir jou 'n paar vrae vra. Weereens, dit is nie 'n toets of 'n evaluasie nie, daar is nie 'n regte of 'n verkeerde antwoord nie. Ons wil by jou leer. As jy nie gemaklik voel om 'n spesifieke vraag te beantwoord nie, kan jy my laat weet en dan kan ons aanbeweeg na die volgende vraag.

1. Hoekom het jy besluit om deel te neem aan hierdie studie?

2. Wat beteken die woord **"geestesgesondheid"** vir jou?
    - Aanmoediging: Hoe sal jy die woord "geestesgesondheid" aan … Kind onder Bespreking (KOB) verduidelik?

   Wat beteken die woorde **"sielkundige welstand"** vir jou?
    - Aanmoediging: Hoe sal die woorde "sielkundige welstand" aan … KOB verduidelik?

   Wat beteken die woorde **"emosionele welstand"** vir jou?
    - Aanmoediging: Hoe sal die woorde "emosionele probleme" aan … KOB verduidelik?

   Wat beteken die woord **"geestesgesondheidsprobleme"** vir jou?
    - Aanmoediging: Hoe sal die woord "geestesgesondheidsprobleme" aan … KOB verduidelik?

Wat beteken die woorde **"sielkundige probleme"** vir jou?

- Aanmoediging: Hoe sal die woorde "sielkundige probleme" aan … KOB verduidelik?

Wat beteken die woorde **"emosionele probleme"** vir jou?

- Aanmoediging: Hoe sal die woorde "emosionele probleme" aan … KOB verduidelik?

3. Wat doen julle, as 'n familie, wanneer iemand in jul familie **geestesgesondheids-probleme** het?
   - Aanmoediging: Wat doen julle, as 'n familie, wanneer … KOB geestesgesondheidsprobleme het?

   … En wanneer iemand in jul familie **sielkundige probleme** het?
   - Aanmoediging: Wat doen julle, as 'n familie, wanneer … KOB sielkundige probleme het?

   … En wanneer iemand in jul familie **emosionele probleme** het?
   - Aanmoediging: Wat doen julle, as 'n familie, wanneer … KOB emosionele probleme het?

   - Aanmoediging: Wat doen julle, as 'n familie, wanneer iemand in jul familie **hartseer** voel?
     … Wanneer … KOB hartseer voel?

     … En wanneer iemand in jul familie **kwaad** voel?
     … Wanneer KOB kwaad voel?

     … En wanneer iemand in jul familie **bang** voel?
     … Wanneer KOB bang voel?

   - Aanmoediging:
     Tree jy en die ma / pa van jou kind op dieselfde manier op?
     Of tree julle twee op verskillende maniere op?

4. Op watter maniere is jy betrokke by die skool?
   - Aanmoediging:
     Wil jy betrokke wees?
     Hou jy daarvan om betrokke te wees?
     Kan jy vir my vertel op watter maniere jy meer betrokke sal wil wees?

5. As ons ‘n program sou ontwikkel om kinders te help met emosionele probleme, om kinders te help om hul negatiewe / slegte gevoelens en negatiewe / slegte gedagtes te ondersoek, en vir hulle leer hoe om dit te hanteer, dink jy dat dit sal help?
   - Aanmoeding: Waarop moet ons die meeste fokus?
     Moet ons die meeste fokus op negatiewe / slegte **gevoelens**?
     Moet ons die meeste fokus op negatiewe / slegte **gedagtes**?
     Moet ons die meeste fokus op negatiewe / slegte **gedrag**?
     Hoekom?

   - Aanmoediging: Watter tipe van aktiwiteite stel jy voor dat ons gebruik in die program om kinders te betrek, om kinders te laat belangstel om deel te neem aan die program?

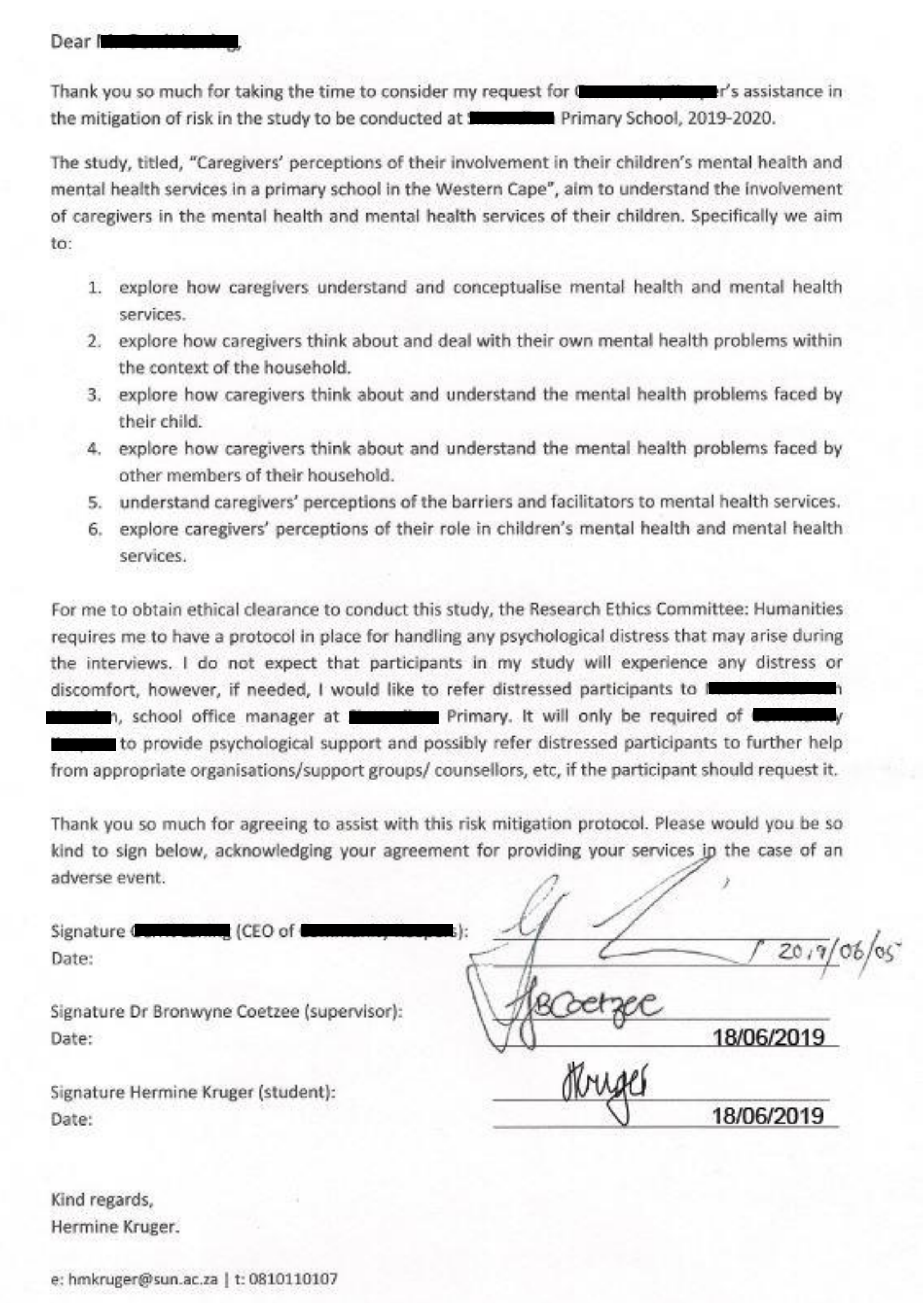
6. Ons dink daaraan om die program met hele klaskamers te implementer (soos byvoorbeeld met die Graad 5A, 5B, en 5C klasse, ens.).
   Dink jy dat dit ‘n goeie idee is? Hoekom / hoekom nie?
   Dink jy dat dit sal werk? Hoekom / hoekom nie?
   Jou gedagtes / idees?

7. Sal jy belangstel daarin om deel te neem aan so ‘n program? Kan jy asseblief verduidelik hoekom / hoekom nie?
   - Aanmoediging: Wat, in jou opinie, sal die beste manier wees om ouers te betrek?
   - Aanmoediging: Wie anders, in jou opinie, sal baat vind by so ‘n program?

8. Het jy al ooit berading ontvang? Het jy al ooit ‘n sielkundige gaan sien?

Dankie.

Appendix I: Approval letter from the NGO



Dear [redacted],

Thank you so much for taking the time to consider my request for [redacted]'s assistance in the mitigation of risk in the study to be conducted at [redacted] Primary School, 2019-2020.

The study, titled, "Caregivers' perceptions of their involvement in their children's mental health and mental health services in a primary school in the Western Cape", aim to understand the involvement of caregivers in the mental health and mental health services of their children. Specifically we aim to:

1. explore how caregivers understand and conceptualise mental health and mental health services.
2. explore how caregivers think about and deal with their own mental health problems within the context of the household.
3. explore how caregivers think about and understand the mental health problems faced by their child.
4. explore how caregivers think about and understand the mental health problems faced by other members of their household.
5. understand caregivers' perceptions of the barriers and facilitators to mental health services.
6. explore caregivers' perceptions of their role in children's mental health and mental health services.

For me to obtain ethical clearance to conduct this study, the Research Ethics Committee: Humanities requires me to have a protocol in place for handling any psychological distress that may arise during the interviews. I do not expect that participants in my study will experience any distress or discomfort, however, if needed, I would like to refer distressed participants to [redacted], school office manager at [redacted] Primary. It will only be required of [redacted] to provide psychological support and possibly refer distressed participants to further help from appropriate organisations/support groups/ counsellors, etc, if the participant should request it.

Thank you so much for agreeing to assist with this risk mitigation protocol. Please would you be so kind to sign below, acknowledging your agreement for providing your services in the case of an adverse event.

Signature [redacted] (CEO of [redacted]):
Date: 2019/06/05

Signature Dr Bronwyne Coetzee (supervisor): BCoetzee
Date: 18/06/2019

Signature Hermine Kruger (student): Kruger
Date: 18/06/2019

Kind regards,
Hermine Kruger.

e: hmkruger@sun.ac.za | t: 0810110107