An exploration of the cultural understanding and help-seeking behaviours of Congolese immigrants in South Africa regarding mental health challenges

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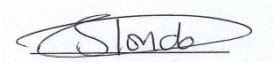
DECLARATION

I, Justine Rachel Ilondo, declare that: **"**An exploration of the cultural understanding and help-seeking behaviours of Congolese immigrants in South Africa regarding mental health challenges'' is my own work, and that all sources that I have used, or have quoted from, have been indicated and acknowledged by means of complete references.

Signature Date



14th August2017

PRAYER

This psalm kept me going throughout this journey and continues to serve as my constant inspiration:

The LORD is my shepherd, I lack nothing.
He makes me lie down in green pastures,
He leads me beside quiet waters, He refreshes my soul.
He guides me along the right paths for His name's sake.

Even though I walk through the darkest valley, I will fear no evil,
for You are with me; Your rod and Your staff, they comfort me.

You prepare a table before me in the presence of my enemies.
You anoint my head with oil; my cup overflows.
Surely Your goodness and love will follow me all the days of my life,
and I will dwell in the house of the LORD forever.

(Psalm 23)

ACKNOWLEDGMENTS

I strongly believe that because the Lord is on my side, I have managed to complete this dissertation within a reasonable timeframe. Having a full time and very demanding job, while pursuing my master's degree, has been one of the most challenging experiences ever. I would like to express my gratitude toward my Heavenly Father for giving me the strength I needed during the whole journey.

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ABSTRACT

The ongoing war in the Democratic Republic of Congo (DRC) has caused sustained trauma on a number of levels and stressors that could easily have debilitating consequences on the mental health of Congolese citizens. The literature further reveals that immigration brings with it a host of additional stressors. The stress related to immigration, an appreciation of diverse cultural understandings of mental health, the burdens and costs of adequate mental health policy and provisioning within developing countries, are concepts that are not well understood nor fully documented.

The present study explored the cultural understanding and help-seeking behaviours of Congolese immigrants in South Africa. The purpose of the study was to understand the ways in which Congolese cope with stressors related to immigration. Using Social Identity Theory as a partial conceptual framework, the role of acculturation processes in their understanding and help-seeking behaviours regarding mental health challenges, were examined. A platform for participants to suggest suitable ways of responding to improving the management of mental challenges in their community was provided.

A qualitative approach, based on Participatory Action Research (PAR) and content analysis to explore the emerging narratives, was used with a Gauteng-based sample to gather the accounts of the lived experiences of Congolese immigrants. A snowball sampling technique enabled twenty-seven respondents to participate in one paired conversation and five focus groups.

The emerging findings are critically discussed aligned to the six categories of inquiry structured by the interview schedule, namely, coping strategies since immigration, the understanding of mental health challenges, the possible impact of being immersed in the South African culture, perceptions of mental challenges and persons affected within the Congolese community, the preferred help-seeking behaviours regarding mental health challenges and, finally, their recommendations for improving the management of mental health challenges. The layered meta-analysis of the data consisted of interrogating the thematic categories, then conducting an analytical review aligned to both the pertinent research aim and objectives, as well as related theoretical positions and research findings.

The key research question underpinning this study was formulated as follows: “Will immigrating from the DRC to South Africa change the understanding and help-seeking behaviours of Congolese?” The study drew on the processes of acculturation from Social Identity Theory to examine these processes. Participants reported experiencing the effects of acculturation but in different ways. Patterns of assimilation, separation and integration were found. The study therefore served to contribute to our understanding of the effects of acculturation with regard to the cultural understanding and help-seeking behaviours of Congolese immigrants in South Africa regarding mental health.

Most significantly, the assumption of high levels of trauma and stress within this vulnerable community were unfounded. Rich and complex survival strategies have emerged requiring refinement of our knowledge about migrant communities. The strengths and relative weaknesses of the study are shared as well as a set of recommendations for future research in this domain.

Key terms: Democratic Republic of Congo, immigration effects, qualitative method and techniques, help-seeking behaviours, acculturation, mental health challenges, focus groups.

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Chapter 1: Introduction and contexts

This chapter provides an explanation of the survival contexts of Congolese citizens, as well as a consideration of the potential impacts of immigration to South Africa. Key notions are defined, such as the relationship between economic deprivation, poverty and mental health challenges, the cyclical relationship between stress and vulnerability, and the notion of immigrants, as it pertains to the study. The framework and the focus of the study is introduced, and then the research problem being addressed is presented. Finally, a chapter outline of the rest of the dissertation is provided.

1.1 The situation in the Democratic Republic of the Congo (DRC)

Communities differ from one another and are often exposed to different realities. Those realities depend on their culture, the environment where those individuals live and the challenges faced by each community at specific moments. As a community, the Congolese have been exposed to challenges linked to the ongoing war in their country, the Democratic Republic of the Congo (DRC).

Various authors have made mention of the war in the DRC, which started in 1996, such as Duroch, McRae and Grais (2011) as well as Mels, Derluyn, Broekaert and Roseel (2009). report that this ongoing conflict has caused more deaths since World War II. Duroch et al (2011) report that around 5.4 million deaths have been recorded between 1996 and 2006, especially in the eastern part of the DRC where the conflicts have been taking place.

However, the rest of the Congolese nation, who are not in the warzone have been affected indirectly by the socioeconomic repercussions of the war. The ongoing armed conflicts have caused negative consequences in the economy, education and the health sectors. Those challenges have caused a high rate of poverty and economic deprivation in the country. Becker and Kleinman (2013) have linked poverty to the following factors, such as socioeconomic, unemployment and literacy level. In other words, poverty has been associated with a low socioeconomic status, unemployment and a low education level.

Several authors have also linked poverty to mental health challenges. According to Jacob (2016), failure to meet basic needs such as having access to clean water, sanitation, nutrition and immunization can have a negative impact on mental health. This is illustrated from the

results of a study conducted by Patel and Kleinman (2013) in six countries, in the following regions of Africa, Asia and in South America. The results from the survey revealed that mental health challenges were triggered by the low income, insecurity, social change, low education levels and hopelessness. While Kuruvilla and Jacob (2007) have also found a link between poverty and mental health burden, they have mentioned that not only poverty through economic deprivation was a risk factor for mental health burdens, but that a diagnosis of mental health burdens was also a risk factor for poverty. That is because individuals diagnosed with mental health conditions tend to battle secure employment and maintain a high socioeconomic status. In this regard, Corrigan and Watson (2002) have also mentioned that mental health patients are often confronted with problems to secure employment, safe housing and even to be affiliated to other people socially.

The same view was supported by Bass, Murray, Cole, Bolton, Poulton, Robinette, Seban, Falb and Annan (2016) who argue that the cycle of poverty consists of mental health patients who are likely to be victims of poverty, while people living in poverty are likely to develop mental health conditions. Adding to the cycle of poverty, Jacob (2013) introduces the cyclical relationship between stress and vulnerability, mentioning that individuals under stress are vulnerable to mental health burdens. Haushofer and Fehr (2014), have also supported the link between poverty and mental health burdens, stating that poor living conditions, dying early and raising children who are likely to face the same challenges, are indicators of poverty.

In the context of the DRC, as one of the consequences of the ongoing war, Kohli, Makambo, Ramazani, Zahiga, Mbika, Safari. Bachunguye, Mirindi and Glass (2012), in describing the resource constrained situation, have pre-empted the dismal ranking outcomes of the DRC in the United Nations Development Program Report (UNDP, 2016). The DRC was ranked 176 out of 188 countries. The UNDP releases an annual report on the state of development of each country, basing its ranking on three indicators, namely, a long healthy life, which is measured by life expectancy, knowledge, measured by the mean years of education or the number of years an adult has spent studying. Finally the ranking is based on the standard of living, which is the gross national income (GNI). According to the UNDP (2016), the GNI has decreased by 46% in the DRC between 1990 and 2015.

The results from the UNDP (2016) study supports the evidence that most Congolese lack basic services, and are victims of economic deprivation. Congolese who are affected by the devastating consequences of the war are not only the Congolese living in those war zones, where people experience violence and rape on a daily basis, but as also mentioned by Bass et al (2016), those exposed to the consequences of the war through poverty and economic deprivation. That is the case of Congolese living outside warzones.

With all the trauma and violence caused by the war and socioeconomic consequences of the war in the DRC, one could easily assume that in such a community a high prevalence of mental health challenges would exist. According to Bavojdan, Towhidi and Rahmati (2011), the World Health Organisation (WHO) refers to mental health as the absence of any mental illness accompanied with a state of social welfare and health. On the other hand, Amuyungu–Nyamongo (2013) refers to mental challenges "as all diagnosable mental disorders characterised by abnormalities in thinking, feelings and behaviour" (p 59).

Kopinak (2015) has provided two definitions, the first one being the one provided by WHO being that 'mental health is a state of well-being in which every individual is able to realize his/her own potential, can cope with the normal stresses of life, work productively and make a contribution to his/ her family and community'(p.22).The second definition provided by Kopinak (2015) has been used by psychiatric experts, who define mental health challenges as 'clinically significant behavioural or psychological syndrome with sufficient personality, mind and/or emotional disorganization that seriously impairs individual and social function with an increased risk of suffering, death, pain, disability or loss of freedom'(p.22).

Becker and Kleinman (2013) have also mentioned that immigration is a consequence of armed conflicts and natural disasters and has its own stressors. In this regard, the notion of immigration is well defined and presented by Bhugra (2004). For the purposes of this study, immigration is considered to be a process which involves the movement of individuals from the area they originate from to a different one, with the intention to live there permanently. While immigrating entails discovering a new environment, immigrants are exposed to challenges at different levels. Bhugra (2004) and Hailu and Ku (2004) have highlighted a few challenges faced by immigrants. Those challenges include looking for a job in order to survive, learning a new language and adapting to a new culture. According to Idemudia,

Williams and Wyatt (2013), the lack of social and emotional support are also likely to trigger mental health challenges among immigrants.

In the Congolese context, those who flee from the DRC are therefore affected by another challenge linked to the decision to immigrate. When immigrating, immigrants do not only have their initial beliefs. Once they settle in a new environment, they are also exposed to a new lifestyle, new customs and beliefs and this situation is best explained by the notion of acculturation. Schwartz, Unger, Zamboanga and Szapocznik (2010) have provided a definition of acculturation, as the changes that take place as a result of contact with culturally different individuals, groups and social influences. It is assumed that the processes of acculturation will have an impact when individuals immigrate. Given that DRC citizens are a very vulnerable community on a number of levels, as argued, the present study explores whether immigrating to South Africa has had an influence on their understanding and help-seeking behaviours with regard mental health challenges.

Immigrants living in South Africa were chosen, because first of all, South Africa itself is a multicultural environment. In other words, when dealing with the understanding and help-seeking behaviours regarding mental health, according to Amayungu-Nyamongo, (2013) different beliefs could be found.

Bhugra, Gupta, Schouler-Ocak, Gallies, Deakin, Qureshi, Dakes, Moussaoui, Kastrup, Tarricone, Till, Bassi and Carta (2014) claim that immigrants are individuals who voluntarily leave their country to settle in another country either permanently of for a long time, usually while looking for better economic opportunities. Refugees, on the other hand, according to Cortes (2004), as well as Bhugra et al (2014), are individuals who have been forced to leave the country to escape from war, natural catastrophes or dangerous political situations. With the challenges linked to the ongoing war in the DRC, even though some have been refugees after running away from war zones, other Congolese are just individuals who have been affected indirectly by an unstable economy.

For the purpose of the present study, those originally from the Congo living in South Africa, will be considered in the present study, with no distinction made between immigrants and refugees, as the study aims to explore the cultural understanding and help-seeking behaviours

of Congolese immigrants in South Africa regarding mental health challenges. Since the study is about exploring the cultural understanding and help-seeking behaviours regarding mental health challenges, the reason for their arrival in South Africa is not relevant. Both refugees and immigrants do share the same culture and beliefs and hence have the same understanding of issues. For the sake of the present study, participants were not asked in which category they belonged. Therefore, in the rest of the study, the term immigrant is used as an umbrella term to include refugees, immigrants and asylum seekers.

The context of the Congolese community presents an image of a community who originate in a country facing an ongoing war, economic deprivation and poverty in their country of origin and more challenges when settling down as immigrants. With mental challenges likely to occur as a consequence of the war, poverty and socioeconomic deprivation, there is a need to explore the cultural understanding, and management of mental health challenges in this community. Furthermore, given the claims made by Hailu and Ku (2004) regarding the consequences of immigration, such as challenges linked to adjustment, learning a new language and adapting to a new culture, the present study will also explore how Congolese immigrants in South Africa have coped with immigration. The study also examines whether the South African culture has influenced their understanding on mental health challenges.

1.2 The research problem

The World Health Organisation (WHO) believes that around 450 million of people are living with a mental illness, and that 75% of the burden related to mental health is found in developing countries (Amayungu-Nyamongo, 2013). A more recent and similar figure was given by Rathod, Pinnity, Gorcynsky, Rathod, Gega and Naem (2017), who report that around 80% of mental health burdens worldwide happen in 153 low and middle income countries.

As mentioned earlier, Patel and Kleinman (2003), Kuruvilla and Jacob (2007), Haushofer and Fehr (2014), as well as Bass et al (2016), have all associated economic deprivation as a trigger for mental health challenges. Due to the current socioeconomic situation in the DRC, immigration is likely to happen, since Bhugra (2004) has identified armed conflicts as one of the causes of immigration.

However, immigrating, according to Hailu and Ku (2004) brings additional challenges too. Those challenges that have been associated with immigrating include learning a new language, looking for a new job, and adjusting to a new culture. Idemudia et al (2013) have also added the lack of emotional and social support among immigrants as a stressor that is likely to lead to trigger mental health challenges. The present investigation will shed some light on the understanding of mental health challenges from a specific immigrant community and aim to provide new insights, as this is an unexplored area. The present study will therefore identify the ways in which mental health challenges are understood and managed in this community.

Finally, the participants of the study, while sharing their understanding and help-seeking behaviours regarding mental health challenges, will also be invited to make suggestions and offer solutions for the suitable treatment of mental health burdens in their community. This is important as immigration patterns and the numbers of dislocated people has become a political and social issue of global concern and magnitude.

1.3 Chapter outline of the rest of the study

Chapter 1 provided an introduction and context, and framed the research problem though examining key notions that explain the DRC context and underpin the possible effects of immigration.

Chapter 2 extends the review of the literature and introduces additional aspects relevant to the study. This chapter discusses the following notions: the occurrence of mental health challenges worldwide, mental health resource constraints as an additional debilitating factor, factors influencing help-seeking behaviours, immigration as a stressful experience, cultural challenges in labelling mental health conditions, barriers in addressing mental health challenges, adapting to new contexts and the onset of mental health challenges.

Chapter 3 presents the rationale, research design and method of the present study. A Participatory Action Research (PAR) approach has been chosen as the method. This chapter furthermore presents the research design, the research plan and the data gathering process, the application of ethical and research principles, the sampling technique, sample size, the data

analysis and interpretation. Finally, chapter 3 ends with a description of the methods used for the data analysis.

Chapter 4 provides the emerging narratives from the focus groups, with each focus group presented in detail. The demographic information on the participants of each focus group is also provided. Detailed analyses of the actual conversations are shared in order to document the actual voices and concerns of this community.

Chapter 5 shares more detail on the content analysis process, introduced in Chapter Three, of the results according to the emerging themes within the structured categories of the interview schedule. The themes emerged according to the following categories: coping strategies since immigration, understanding of mental health challenges, the impact of the South African culture on understanding of mental health challenges, mental health challenges in the Congolese community, perceptions of those suffering from mental health challenges, and help-seeking behaviours. Finally chapter 5 ends with recommendations from the participants in order to improve the treatment of mental health challenges in their community.

Chapter 6 presents a layered meta-analysis as an interpretation of the findings. The different themes identified during the focus group sessions are examined against the existing literature. In this chapter, the key summative findings are also put into context and are presented in response to the overarching research question and supporting objectives.

Chapter 7 presents the significance and shortcomings of the study. The strengths and weaknesses of the present study are pointed out. The chapter also mentions some suggestions for future research. The dissertation ends concluding reflections.

Chapter 2: Literature review

A more comprehensive review of the literature introduces the key dimensions for locating the study, building upon the previous section which has introduced some key definitions. This section starts with an observation on the occurrence of mental health challenges worldwide, then focuses on mental health resource constraints as an additional debilitating factor, the factors influencing help-seeking behaviours, immigration as a stressful experience, the cultural aspects in labelling mental health challenges, barriers in addressing mental health challenges, adapting to new contexts and the onset of mental health challenges. It is important to explore different contexts regarding the understanding and help-seeking behaviours regarding mental health challenges in order to understand the possible ways in which Congolese immigrants might understand and manage their expected mental health burdens.

2.1 The occurrence of mental health challenges worldwide

In previous American studies, which examined the prevalence of clinical depression across races, conflicting results were found. In one study, there was a higher rate of clinical depression amongst white Americans. However, in another study, there was a higher rate among African Americans (Riolo, Nguyen and Gerden, 2005). The latter was explained by the fact that on one hand, the higher rate of clinical depression among African Americans was due to the fact that most of the time, when suffering from depression, African Americans do not seek treatment, leading to less registered cases of depression for this group (Riolo et al, 2005). On the other hand, the high rate of depression among African Americans was explained by the fact that most African Americans come from a background characterised by poverty, violence and other stressors leading to higher rates of depression (Riolo et al, 2005). The situation pointed out by Ganasen, Parker, Hugo, Stein, Emsley and Seedat (2008) can partly explain Riolo's findings, with non-treated cases influencing the low prevalence of

mental health challenges such as depression. That is because a large number of patients affected by mental health challenges did not seek help.

Ganasen et al (2008) refer to a survey conducted by the World Health Organisation (WHO) in fourteen (14) countries, with six (6) of those countries being less developed and eight (8) countries being more developed. Those countries were classified according to the resources allocated to the treatment of mental health challenges. The purpose of that survey was to establish the occurrence of mental health challenges in countries with different levels of development. The result of the survey revealed that up to 50% of mental health burdens from developed countries and 85% in less developed countries were not treated.

The results from the survey conducted by the World Health Organisation(WHO) shows consistency with the view from Amuyungu-Nyamongo (2013) ,who stated that mental health challenges are found in both developed and developing countries. While 14% of health burdens have been attributed to mental health challenges globally, Ganassen et al (2008) indicate that up to 75% of health burdens are from mental health challenges in developing countries. Rathod et al (2016) have allocated 80% of health burdens to low income countries.

Kinyanda, Woodburn, Tugumisirize, Kagugube, Ndyanabangi and Patel (2011) have pointed out that countries such as South Africa, Japan and Uganda, have high rates of suicide, which often occurs as a result of a mental illness. South Africa and Uganda have been classified as developing countries and Japan as a developed country. All three share the same mental health burden of high rates of depression and suicide, showing that mental health challenges do not only occur in developed countries, but in all countries and communities regardless of race , according to Kinyanda et al (2011).

When having a closer look at African countries, factors such as wars and natural disasters are seen as triggers for mental health challenges, as around 50 % of refugees are believed to suffer from a mental illness (Amuyungu-Nyamingo, 2013).These claims shared similar views with Rathod et al (2017) who have identified poverty, natural disasters and armed conflicts as some of the causes of mental health challenges. These challenges, once again, resemble those seen in the Democratic Republic of Congo (DRC) where millions of refugees have been moving across war zones. In one of the most dangerous war zones in the eastern parts of the

DRC, there are three active volcanoes, which have erupted a few times during the same period when armed conflicts have taken place.

These trends relate to the present study and fit in well with the World Health Organisation's (WHO) definition of mental health challenges, as follows:

> 'Mental disorders occur in persons of all genders, ages, and backgrounds. No group is immune to mental disorders, but the risk is higher among the poor, homeless, the unemployed, persons with low education' (2007 p.273).

Not only does the quotation highlight the occurrence of mental health challenges across people of all genders, ages, backgrounds and communities, the high risks mentioned are part of the consequences of the war in the DRC. Therefore, it is important to explore the understanding and help seeing behaviour regarding mental health challenges in the Congolese community.

2.2 Mental health resource constraints as an additional debilitating factor

Despite the fact that mental health challenges do affect every country, including developing ones, there is a low budget allocated to mental health services in African countries. For example, Liberia has 0, 6 mental health professionals for every 1 million people, with similar situations in Lesotho, Zimbabwe and other countries (Amuyungu-Nyamongo, 2013).

In the DRC, Kohli et al (2012) have highlighted the fact that before the war, the resources were already not enough for all Congolese, and the armed conflicts have made the problem worse. The lack of psychiatric hospitals has favoured the use of 'listening houses', which are places where victims of domestic violence and other traumatic events can come to seek help, by talking to someone about what they have been going through. This situation with the lack of medical resources in general, and psychiatric ones in particular, is common to both other low income countries (LICs) and low and middle income countries (LMICs).

The lack of suitable psychiatric services in most developing countries occurs, according to Ngcobo and Pillay (2008), because those developing countries, especially in Sub-Saharan Africa experience different health burdens, like infectious diseases or AIDS as a pandemic, and the few available resources are allocated to infectious diseases.

Despite the fact that in developing countries, there are very few psychiatric hospitals and mental health practitioners, mental health challenges are responsible for health burdens in both developed and developing countries, where, according to Ruthod et al (2017) 80% of mental health burdens are to be found. Added to the high rate of mental health burdens in developing countries, Becker and Kleinman (2013) claim that 80% of people with severe mental health burdens to not get treatment in developing countries.

When it comes to the resources for the management of mental health challenges, Kenya has been mentioned by Amuyungu-Nyamongo (2013) as one of the countries with a slightly higher number of mental health professionals. There are around 47 psychiatrists to be found in the country, with 22 in the capital city, Nairobi, and the rest scattered around the country. On the other hand, developed countries offer accessible mental health care to all patients, from medical professionals, psychiatric beds and insurance plans allowing patients to get suitable treatment for any form of mental illness.

These arguments can easily be associated with the present study, where the participants are from a developing country, the DRC, which has scarce resources to treat mental health challenges. Mentioning the scarcity of resources to manage mental health challenges in developing countries in general, and in the DRC in particular, is a way to justify that with the context of the war and socioeconomic problems, adding to the difficulty in finding facilities to manage mental health burdens, one can assume that many individuals in the Congolese community would be affected by mental health burdens. That is why the present study will be exploring not only the understanding of Congolese immigrants but also their chosen help-seeking behaviours regarding mental health challenges.

2.3. Factors influencing help-seeking behaviours

Ngcobo and Pillay (2008) have mentioned financial status as a factor influencing help-seeking behaviour. In their paper, one of the reasons why women in South Africa relied solely on traditional healers was because with traditional healers, a donation was required but psychiatric care required more money for consultation. It is however important to note that the choice of alternative healing is not completely due to financial reasons, but to beliefs, as stated by Rathod et al (2017). In some cultures mental health challenges are associated with bad luck and bad spirits. Those beliefs will then influence the chosen treatment for those

mental health challenges. The importance of beliefs in the management of mental health disorders is highlighted by findings in India, where 82% of people have rejected Cognitive Behaviour Therapy (CBT) as a method of treatment for mental health challenges. According to those patients, CBT was against their cultural beliefs, with a further 40% of patients claiming that CBT was against their religious beliefs (Rathod et al, 2017)

The influence of beliefs in the preferred method of help-seeking behaviours can further be linked to the findings from a study conducted by Ventevogel, Jordaans, Reis, and De Jong, J (2013). The authors explored the help-seeking behaviours of different communities in Uganda, and the eastern DRC. The results revealed that when those communities believed that the cause of the condition was supernatural, the help-seeking behaviours were more likely to be a spiritual intervention. Given the role of culture and beliefs in the chosen help-seeking behaviours of mental health challenges, these aspects will be explored since they could relate to the present study regarding Congolese immigrants.

Ellis, Lincoln, Charney, Ford-Panzer, Benson and Strunin (2010) have also pointed to the importance of individual beliefs in the choice of help-seeking behaviour. For instance, in their paper, they mentioned how Somali immigrant students in the United States of America, did not make use of the psychiatric services offered to them, due to religious beliefs and the high stigma associated with mental health burdens. Finally, Ganassen et al (2008) have mentioned poor mental health literacy as a factor influencing help-seeking behaviours.

Patel, Araya, Chatterjee, Chisholm, Cohen, De Silva, Hosmanc, Guire, Rojas and Vanommeren (2007) also believe that the lack of facilities and professionals to treat mental health challenges, added to the socio-cultural as well as religious beliefs, force those individuals from under-resourced areas to either rely on their communities for support and healing, or to rely on prayers and pastoral counselling. This is confirmed by as well as Rathod et al (2017).

The examples and contexts given from the literature indicates that one’s financial status, social beliefs, religion and mental health literacy all have an influence on help-seeking behaviour. The present study will allow us to explore the cultural understanding and help-seeking behaviour of Congolese immigrants in South Africa and make a contribution to knowledge about this specific community within a developing region.

2.4 Immigration as a stressful experience

As previously mentioned in the previous section, Bhugra (2004) has defined immigration as the voluntary movement from one's place of residence to another, with the intention to live there permanently. In the South African context, Idemudia et al (2013) quoted the former Minister of Home Affairs, who claimed that there were more immigrants from other African countries in South Africa because when compared to most other African countries, as South Africa is more advanced. Secondly, both skilled and illegal immigrants are able to find jobs in South Africa. The final argument given by the former minister of Home affairs regarding the afflux of immigrants in South Africa was because he believed that other Southern African countries are connected to South Africa historically.

Despite the claim from the former minister of Home Affairs, Idemudia et al(2013) mentioned how immigrants in general, and Zimbabweans in particular, were exploited. The latter were struggling to secure jobs and did not have access to enough opportunities in South Africa.

No literature on the situation of Congolese immigrants in South Africa was found, but the challenges faced by Zimbabweans immigrants resemble what Congolese as immigrants face too. Since the present study will be exploring the cultural understanding and help-seeking behaviours of Congolese immigrants, it is important to understand the context in which Congolese immigrants and those from other African countries find themselves in. The study will allow us to understand how Congolese immigrants cope with stressors associated with immigration in South Africa.

2.5 Cultural challenges in labelling mental health conditions

In most African cultures, it is difficult to label a specific mental illness such as depression. Some languages do not have an exact word for depression. This is the case for the Zulu language. The same applies for translation into a Zimbabwean language, where people who experience symptoms of depression, when explaining to the doctor, mention kubuhlungu, or inhliziyo, which can be translated as having a pain in the chest (Ngcobo and Pillay, 2008). The authors further report that in Kenya, similar patterns have been identified, where symptoms of depression have been attributed to "thinking too much'' .That is why the present study will be exploring the understanding of Congolese immigrants regarding mental health

challenges to see whether their understanding is also different from the western way of labelling mental health challenges.

Preferred treatment options for the treatment of those mental health challenges will also be investigated. Kopinak (2015) also mentioned that South African studies have revealed that the use of a translator who could not translate properly led to inaccurate assessments of mental health disorders.

This study will examine whether the help-seeking behaviours from the Congolese immigrants will depend on the understanding they have regarding mental health challenges, on the availability of facilities to treat those mental health challenges, or on the beliefs held regarding mental health. For Congolese immigrants, who are from a country with vernacular languages, where definitions of mental health challenges do not have direct translations like in the languages mentioned above, the present study explores and will describe the way Congolese understand mental health challenges.

2.6 Barriers to addressing mental health challenges

According to Amuyungu-Nyamongo (2013), African communities are not particularly empathetic towards those affected by mental health challenges. Not only do some psychiatric services isolate and tie patients down, those in the community face rejection, and for women a possibility of not getting married. Ciftci, Jones, and Corrigan (2013) have also associated rejecton and stigmatisation towards those affected by mental health challenges in many communities. Furthermore, Dinos, Stevens, Sefaty, Weich and King (2004) have conducted a qualitative study where the results showed stigmatisation of patients affected by psychotic disorders and drug abuse and those affected by mood disorders were facing patronising attitudes from other people. This view was further supported by Corrigan, Morris, Michaels, Rafacz and Rushch (2012) who have acknowledged that discrimination and stigma have detrimental effects towards mental health patients. Mantovani, Pizzolani and Edge (2016) have also stated that those affected by mental health challenges are more discriminated against, compared to those diagnosed with other medical conditions.

Previous studies have shown that the treatment of clinical depression has been influenced by cultural factors. Adding to the cultural factors already mentioned, stigma is a cause of the

reluctance to use psychiatric facilities. Ellis et al (2010) have mentioned the case of Somali adolescent refugees who were found to be very reluctant to use mental health facilities made available to them while living in America, as a result of their beliefs, discussed in the previous section, and the stigma around mental health.

Another sign that stigma is the reason of the reluctance for using psychiatric facilities in most African communities, can be explained by a study that revealed that many people who experience symptoms of mental health challenges such as depression prefer going to see a general practitioner, rather than a psychiatrist (Tomlinson, Grimsrud, Stein, Williams and Myer, 2009).The stigmatisation process as stated by Becker and Kleinman (2013) included the stigma towards both the patients and the mental health practitioners.

A study conducted by Ellis et al (2010) pointed out that even though women from Punjabi acknowledged the symptoms of clinical depression, they did not see depression as a medical condition. Those women then used prayers, meditations, and support from loved ones in order to address depression, rather than consulting a doctor. According to those women, depression is something that can happen to anyone, at any time and one just needs to move on.

Another South African study by Ganassen et al (2008), reported that the majority of those who were diagnosed with a mental illness waited between three and five years before getting treatment, the reason being those patients did not know where to go for help.

By exploring the understanding and responses to mental health challenges, the present study will explore whether Congolese immigrants are also exposed to and how they deal with mental health stigmatisation and other barriers, and which solutions they suggest in order to manage mental health challenges better within their community.

2.7 Adapting to new contexts

Given the nature of this dislocated community, it would be important to understand how they adapt in new settings and what survival processes are at play. A helpful construct in this regard might be that of acculturation.

Schwartz, Unger, Zamboanga, and Szapocnik (2010) have defined acculturation as the changes that occur when individuals are in contact with a different culture, diverse people, group and social influences. Bhui, Stansfeld, Head, Haines, Hillier, Taylor, Viner and Booy

(2005) have also provided a similar definition by stating that acculturation can be defined as ‘‘the phenomena which results when groups of individuals having different cultures come into continuous first hand contact with subsequent changes in the original cultural patterns of either or both groups (p.296). Schwartz et al (2010) have identified four dimensions that have been associated with acculturation and these dimensions include assimilation, separation, integration and marginalisation.

Bhui et al (2010) further defined the important concepts of assimilation and integration as follows. Firstly, assimilation is the process whereby individuals reject their initial culture in order to adopt the cultural values from the host country. Secondly, the process of integration is explained as immigrants keeping their own country values while adopting some of the host culture. Furthermore, according to Ndika (2013), separation is when immigrants keep their own culture without adopting the new culture, and finally marginalisation is the pattern of acculturation when the immigrants reject their own culture as well as the new culture.

Acculturation has been identified as a very relevant variable in the present study. It is important to know to what extent acculturation will play a role in the Congolese immigrants' cultural understanding and help-seeking behaviours regarding mental health challenges.

It is therefore important to explore whether Congolese immigrants are more attached to the beliefs held in their home country, when dealing with mental health challenges, or whether they have changed the way of understanding mental health challenges and help-seeking behaviours regarding those mental health challenges, due to acculturation.

2.8 Social Identity Theory as a partial framework

Social Identity Theory is considered to offer a partial explanatory framework for the present study. By exploring the cultural understanding of Congolese immigrants, the study will establish the extent to which a sense of belonging to the Congolese or host community will influence not only the understanding of mental health challenges, but also help-seeking behaviours.

According to Tajfel and Turner (1979), Social Identity Theory explains personal cognition and and behaviour in relation to group processes. According to this perspective, individuals tend to associate the sense of who they are based on the group they belong to. Furthermore,

Tajfel and Turner (1979) believe that the idea of the self is defined by the group an individual belongs to. According to Burke (2009), human beings are social beings. In other words, they do not live in isolation, but always belong to a group.

Social Identity Theory includes three steps with the first step one being social categorisation. During the social categorization step, individuals associate different individuals with the characteristic those individuals have in common. This step is taken, according to Tajfel and Turner (1979) to simplify the way individuals understand the world. Social categorization results in structures to facilitate interaction, hopes and fears. The second step entails social identification, when individuals associate themselves with the group where they belong. Finally comes social comparison, which is a step triggered by social categorization. Social comparison happens when individuals from one group start comparing themselves to individuals from other groups. Since one's sense is based on the group membership, one tends to enhance the quality or doings of the group one belongs to. This is a way of increasing one's self esteem.

Tajfel and Turner (1979) claim that social identity is a plausible background for identity related gratification. Furthermore, when one's self esteem is under threat, one tends to bring other groups down, referred to by Tajfel et al (1979) as the self-esteem hypothesis.

Social identity is only used as partial framework for the present study because it might help understanding the way Congolese, as immigrants, categorise themselves as a group. The theory does not provide a full explanation for the whole study as the politics of poverty and resilience are not addressed in a meaningful manner. Social Identity Theory might offer an explanation of the choice of different help-seeking behaviours. It is therefore important to explore whether Congolese immigrants are more attached to their historic cultural beliefs, when dealing with mental health challenges, or whether changes to the way of understanding mental illnesses and help-seeking behaviours regarding those mental illnesses, have happened due to acculturation.

2.8 The onset of mental health challenges

Numerous studies have been conducted in order to determine the onset of mental health challenges. Even though it has been said that it is not easy to determine the onset of mental

health challenges, through surveys and research, some researchers have managed to understand more about the onset of mental health challenges.

The WHO conducted a survey across 48 countries. The purpose of that survey was to determine the onset of mental health challenges. The survey was done using the Composite Diagnostic Interview and the fourth version of the Diagnostic and Statistical Manual for mental disorders (DSM IV), according to Kessler, Amminger, Aguilar-Gaxiola, Alonso, Lee and Ustun (2007).Even though the article mentioned used the DSMIV, there is a more recent version, the DSM which is used nowadays as the diagnostic tool for psychiatric disorders.

The results from the sixteen (16) countries who submitted the results of the survey revealed that the onset of mental health challenges occur in either childhood or late adolescence. It is, however important to separate the types of mental disorders in order to establish the onset of those conditions. Mood disorders, according to Jones (2013) can have an onset during childhood. This claim shows consistency with results of a study conducted in the United States where children as young as 6 years old were diagnosed with anxiety (McGorry, Purcell, Goldstone and Amminger, 2011).

When it comes to developmental disorders, according to the 10th revision of the International Statistical Classification of Diseases) and related Health Problems (ICD) published in (2014), neurodevelopmental disorders such as autism tend to be diagnosed during childhood. On the other hand, neurocognitive disorders, and psychotic disorders, as revealed by Jones (2013) and Kessler et al (2007), are often diagnosed during adulthood. It is, however important to note that even though the results of the survey conducted by the WHO mentioned that even though the onset occurs during childhood or during late adolescence, the diagnosis and treatment usually takes place years after the onset (Kessler, Berglund, Demler, Jin, Merikangas and Walters, 2005). Despite the findings on the onset of mood disorders, Kessler et al (2007) stated that the prevalence of mood disorders was high between 25 and 32 year old adults. These results show consistency with findings from Jones (2013) stating that mental health disorders that manifest around the age of twenty-six (26) should be considered as problems that arose during adolescence. The findings also revealed that the results collected from different countries were the same and unrelated to economic development, and the geographic location of patients. Even though the onset of mental health challenges generally occurs during childhood or late adolescence, the diagnosis takes place at a median age of 26

years of age. To fully comprehend the patterns of the onset of mental health challenges and the capacity to respond in meaningful ways, the purposive sampling technique identified participants older than 25.

This chapter has presented an overview of the key notions that underpin the present study, extracted from the review of existing literature. The next chapter will frame the rationale for the study, the research aim, as well as the research question supporting objectives as well as a detailed section on the research design.

Chapter 3: Rationale, research design and method

3.1 Rationale

The WHO defines health as an individual's complete state of physical, mental as well as social wellbeing (Ustun and Jacob, 2005). Therefore, for an individual to be considered healthy, one's mental as well as one's physical state need to be as fully functional (Ustun and Jacob, 2005). Furthermore, the WHO acknowledges that depression will be the second leading cause of disability by 2050 in the world (Kinyanda, Kizza, Abbo, Ndyanabangi and Levin, 2013). More recent projections mentioned by Rathod et al (2017) mention that in 2030, mental health challenges will be the third cause of disease burden in low income countries and the second in middle income countries. Based on the fact that mental health burdens are among the leading causes of disability in the world, and that mental health challenges are understood and managed differently across cultures, it is important to explore how respective communities understand and manage mental health challenges.

Besides the heavy trauma and all the stressors that Congolese have been exposed to, the very few resources available to treat mental health challenges in the DRC makes the study important. There is scant information about what mental health challenges mean to this community, and their preferred help-seeking behaviours when addressing mental health challenges.

According to Saxena, Thornicrof, Knapp and Whiteford (2007) resources in terms of mental health include the following, policy, available infrastructure within countries, community resources, human resources and funding. Even though South Africa has also been compared to other low income countries in terms of resources available to treat mental health challenges, the country does have comparatively more resources available for mental health management.

Saxena et al (2007) highlighted the availability of resources to treat mental health challenges. In low income countries, there is an average of 0.32 psychiatrists and 10 psychiatric nurses for 100 000 patients. On the other hand, high income countries have 200 times more resources

than those allocated to low income countries. South Africa, despite being a low income country has 0.77 psychiatrists, 10 psychiatrist nurses and 24 beds for 100 000 patients (Burns, 2011). Despite a higher number of resources allocated to mental health than in the DRC, there was a recent incident where 94 psychiatric patients died in a long term psychiatric care facility in South Africa, after being transferred to non-governmental organisations (NGOs) not equipped enough to provide the adequate care to psychiatric patients. This incident that affected former patients of the Life Esidimeni care facility in South Africa shows a similarity between South Africa and the DRC, that of poor systems and some serious negligence in the handling of mental health care and services.

While the information provided by the WHO does not have clear data for the number of mental health professionals in the Democratic Republic of Congo, it is known that in the Democratic Republic of Congo, a country of 2 345 000 1 km² with a population of 51 million, there is only one major psychiatric clinic, for both children and adults, in the whole country (Kashala, Sommerfelt and Teacher, 2005).

Furthermore, one third of countries worldwide, most of them developing countries, do not have mental health policies that protect the human rights of mentally ill patients. Most developing countries with mental health policies have very old policies that have been developed over 30 years ago, which means that the outdated policies lack recent developments in mental health findings (Saxena et al, 2007).

The present study was conducted to explore not only the cultural understanding of Congolese immigrants and the effect of acculturation on the Congolese immigrants' understanding of mental health challenges, but also examined their help-seeking behaviours concerning mental health challenges. Suggestions on suitable ways to manage mental health burdens within their communities was included as a category. The present study could then contribute at policy and planning level, to inform suitable methods of treatment based on the need and beliefs of the community members.

In addition to the existing levels of trauma experienced by the Congolese community, immigrating also brings challenges and additional traumatic experiences. Those challenges include looking for employment in a very competitive job market, not benefiting from social advantages such as a generous social grant for their children, and not benefiting from free

accommodation or free tuition fees for tertiary education. Furthermore, immigrants in South Africa in general, and the Congolese ones in particular, have been victims of xenophobic attacks over the years. During those attacks, some of those immigrants were exposed to violence, insecurity, looting and death threats. The xenophobic attacks have always added another challenge to those Congolese immigrants living in South Africa, namely, the sense of not being fully integrated into South Africa as a society.

It is therefore important to understand not only the challenges faced by immigrants but also to address those mental health burdens according to their respective cultural understanding, in order to provide relevant treatment. Another aspect that shows the relevance of this study is that, not only health is a basic human right, but mental health is part of the complete state of one's health. In other words, addressing mental health problems in a community is a way of contributing to that community's wellbeing. It is also a way to ensure that the human rights of individuals are being respected while suitable treatment will be provided according to respective beliefs.

Finally, another reason justifying the relevance of the present study is that Ganasen et al (2008), pointed out the importance of mental health literacy, and for future research, the relationship between better mental health literacy and the improvement in a population's mental health was suggested. The authors also pointed out the fact that many communities hold beliefs that are usually different from one culture to another. It then remains crucial to explore those beliefs that are particular to each community.

This study will therefore fill in this gap in existing research by exploring the cultural understanding and help-seeking behaviours of Congolese immigrants in South Africa regarding mental health challenges. The present study will also be able to identify all the different help-seeking behaviours used by the community and might provide solutions in order to improve the management of mental health challenges in their community. Therefore, the results from the present study will also address the gap addressed by Ganassen et al (2008) with regard to the relationship between mental health understanding and the improvement in a population's mental health.

3.2 A qualitative research approach as the preferred paradigm

In this section of the chapter, the research approach was used to conduct this study is presented. Furthermore, the research design which, according to Polit and Beck (2008) is defined as the plan followed in order to accomplish a specific project, will be discussed in detail.

A qualitative approach is important for studies that require detailed information regarding the respondents. According to Joubert and Ehlecht (2007), a qualitative approach is required when exploring the understanding of people's feelings, beliefs and values. Furthermore, Terreblanche, Durrheim, and Painter (2006) claim that studies that require the description and interpretation of people's experiences require qualitative research.

In this specific study, the lived experiences of a small sample of Congolese immigrants was explored. In other words, participants provided detailed and subjective information, which was necessary to explore their cultural understanding and help-seeking behaviours regarding mental health challenges. For such studies, open-ended and inductive exploration is needed to explore the behaviour being studied (Terreblanche et al, 2006).

For example, studies that explore why certain behaviours occur, or why certain services or policies in place seem inefficient, are generally conducted using the qualitative approach. That is because those kinds of studies require the study of the subjective experiences of the respondents or their lived experiences (Polit and Beck, 2008).

3.2.1 Participatory action research

A participatory action research method has been selected as the intervention type because according to Baum, MacDougall and Smith (2006), as well as Mc Donald (2012), participatory action research (PAR) is about generating findings that will serve the purpose of empowering the participants. Furthermore, Baum et al (2006) et al have further stated that participatory action research is suitable for studies where the researcher works in partnership, or facilitates the co-construction, with the participants in order to find solutions that will contribute to the participant's wellbeing

The choice of method is influenced by a study conducted by Etowa, Bernard, Oyisan, and Clow (2007) which tried to improve black women's health in rural and remote communities.

The initial assumption, that black women are susceptible to social deprivation, was tested and explored. As a result, an intervention plan had to be drawn up to improve the lives of those black women. Participants played an active part in the study, which resulted in improving their lives. The same scenario was planned in the present study, with a community of Congolese immigrants living in South Africa, participating to provide answers and solutions regarding effective ways to treat the expected mental health challenges in their community.

3.3 Key research questions and supporting objectives

3.3.1 Research question

The present study attempted to answer the following overarching key research question: How do Congolese immigrants understand mental health challenges and what are their preferred help-seeking behaviours?

3.3.2 Supporting research objectives

There are five major research objectives that underpin the study in an attempt to provide answers to the key research question:

1. To explore the understandings of mental health challenges in a sample of Congolese immigrants
2. To explore whether moving from the DRC to South Africa has influenced the cultural understanding of mental health challenges
3. To understand their coping strategies with regard to the identified stressors linked to immigration
4. To describe the preferred help-seeking behaviours
5. To generate recommendations for how the situation could be improved

3.4 Research design

3.4.1 Sampling strategies

The sampling technique was informed by Terreblanche et al, (2006) as well as Joubert and Ehrlech (2007), whose recommendations showed that a convenient sample would be more suitable for the present study. A convenient sample can be defined as a sample where participants are recruited based on their availability and based on the facts that they respond to the criteria needed for the study. However, for this specific study, a snowballing technique was used. Snowball sampling, which is a subtype of the convenient sampling method, is defined by Joubert and Ehrlech (2007) as a sampling technique where subjects are obtained through networking, or by referring other subjects to the research, based on the eligibility of the subjects.

Terreblanche et al (2006) stated that qualitative studies do not require large samples. That is because in qualitative studies, data collection ends once saturation is reached. In other words, when the researcher is no longer getting new answers and the responses from the participants become repetitive.

For the present study, twenty seven (N=27) individuals were included. The participants were then facilitated into conversations depending on their availability. The first paired conversation was followed by six participants in each of the remaining focus group conversations.

3.4.2 Participants

Participants from the present study were recruited from several places that are popular among Congolese, in certain suburbs like Rosettenville, students at universities, hair salons, a church and one of the focus groups were approached through family friends. Participants were recruited by the means of adverts placed on social media and on *Franco-sa*, an online media targeting French Speakers immigrants living in South Africa. Finally, through networks of people from the Congolese community living in South Africa, immigrants living in Gauteng were informed about the current study.

The Gauteng area was chosen in order to allow me to travel easily to meet the participants for focus group sessions. Places where the focus group sessions were held differed, and those places depended on the participants' location, or ability to gather in groups. One of the sessions was held in a public library, as per the respondent's request. Another session took place at the church were all the group members were attending. The third session took place at a hair salon where the respondents were working. The rest of the focus group sessions took place in one of the group members' homes.

In the present study, the cultural understanding of Congolese immigrants living in South Africa is being explored. Since acculturation has been identified as a variable to see whether immigrating has changed their understanding regarding mental health challenges, it is important for the participants to be Congolese immigrants living in South Africa but who were born in the Democratic Republic of Congo and were raised in a Congolese household.

The inclusion criteria can be defined as the set of criteria that make respondents eligible for a specific study. The following criteria, extracted from the review of the literature, were necessary for participating in the study, in addition to the criterion that all participants had to be twenty-five (25) years or older.

Age as a criteria for inclusion was determined by previous research such as that of Reavley, Ross, Killackey and Jorm (2013), who argue that the onset of mental health challenges take place in late adolescence. This position shows consistency with views from Kessler et al (2005). As previously mentioned, not all mental health challenges have the same age onset. Even though mood disorders and neurodevelopmental disorders may be diagnosed during childhood, Ganasen et al (2008) patients usually take years before seeking treatment or getting a diagnosis. That is why people tend to be diagnosed with mental health challenges only in their mid-twenties.

- The participants are Congolese adults who immigrated to South Africa and were not born in South Africa
- Before moving to South Africa, those respondents must have been living in the Democratic Republic of Congo

3.5 Method

3.5.1 Data gathering techniques

A *semi-structured interview* allowed me to gather the data for the study. Terreblanche et al (2006) have mentioned semi-structured interviews as a suitable way to gather information when conducting qualitative research. The semi-structured interview was conducted with questions which were formulated based on the literature review and the aim of the study. The questions formulated for the semi-structured interview allowed the participants to provide answers to the overarching research question through the five supporting objectives of the research design.

According to Boynton and Greenhalgh (2004) and Leung (2001) studies that require obtaining information on knowledge, beliefs and attitudes require the use of open questions. Furthermore, the present study, which shares similar characteristics with research conducted by Etowa et al (2007), used a similar method to design the research instrument.

Demographic information of the sample was also obtained, in order to profile the participants and to add another layer of analysis to describing the respective groups. The demographic information included the following four aspects:

1. Age
2. Gender
3. Location and duration
4. Year of immigration

The qualitative data was collected through direct interaction between the participants as I facilitated and recorded the focus group conversations. As stated by Baum et al (2006), the interpretation draws from Participatory Action Research (PAR), as a qualitative study takes place simultaneously as the data gathering process. Immersion into the process took place during this phase, since I was learning to listen carefully to the information provided by the participants, and getting familiar with note taking. Some participants preferred speaking in French, and others in English. There were also cases where the participants were mixing both languages. I did not have any challenges in this regard since I am fluent in both French and English.

Focus groups involve a group of people gathered as a group where participants talk to one another while being guided by a facilitator. The importance of a focus group is to gain more insight into the attitudes and opinions of participants. Since the present study was exploring the cultural understanding and help-seeking behaviours of Congolese immigrants in South Africa, facilitated focus group conversations were the perfect medium to engage and guide the participants.

For the present study, the following questions were formulated following recommendations from Leung (2001):

- How have you coped since immigrating?
- What do you understand by mental health challenges?
- How has living in South Africa change your understanding of mental health challenges?
- Can you tell us about the presence of people affected by mental health challenges in your community?
- What do you think about those suffering from mental health challenges?
- What kind of help do they seek and from whom?
- How could this situation be improved?

I advertised the need for people to participate in the current study by using various media platforms. First, social networks were used. Then, an advert was also placed in *Franco-SA*, an online media platform targeting French speaking immigrants living in South Africa. Congolese immigrants were required and those interested were asked to contact the researcher by sending an email or by calling or sending a message using the short messaging service (sms) to the phone number provided.

Furthermore, as a Congolese citizen, I contacted fellow Congolese citizens I knew, in order to find participants that meet the inclusion criteria of the present study. The people initially contacted were asked to mention the research to fellow Congolese immigrants with whom

they could form homogenous groups. I then made contact with all those people on a regular basis, until days, times and venues were chosen, at the respondents' convenience.

After setting up an appointment with respective group members, I introduced myself. I then explained the reason of the focus group session. Participants were told that they were being interviewed to gather data for a master's dissertation. I gathered participants together and focus groups were formed, with two to seven participants per group. The sessions were recorded using a recording device. While the session was being recorded, I also took notes.

Once the sessions were completed, using the recordings and notes, I summarized the answers according to themes, in order to analyse the data gathered during the focus group session. Data collection stopped when saturation was reached. In other words, when there was no new information being brought up during the sessions.

3.6 Content analysis of the emerging data

Since an exploratory research study was conducted, a content analysis was used, similar in approach to a study conducted by Mabuuke and Leibowitz (2013). The latter study was about exploring the keys to successful implementation of innovation in health professions education.

As a qualitative study, data collection and analysis were conducted in an iterative fashion. Terreblanche et al (2006) has identified different steps while using content analysis for a qualitative study. Those steps include: familiarising and immersion, inducting themes, coding, elaboration and interpretation.

During familiarisation and immersion, as mentioned earlier, I made myself familiar with the notes and the information obtained from the contributions of the participants during the focus group sessions. Then, I induced the emerging themes, extracting and identifying the subjective information from the participants. I then coded the themes identified during the second phase in order to provide meanings to those themes. At the same time, I explored the themes more closely once again, and I identified themes that were either left out or that were presented with some nuances. The interview format provided the structure against which the content analysis process was managed. Finally I proceeded to the interpretation of the

information gathered. Contradictions and unique contributions were noted as the information was being synthesised.

3.7 Applying ethical and research principles

This section shares the processes through which I applied key ethical and professional research concepts during the research process. Ethics is a term that includes all moral behaviours and standard governing the conduct of a person or the members of a profession. When conducting research, ethical behaviour is important to protect the participants and prevent misconduct or plagiarism during the research process (Terreblanche et al, 2006).

There are principles that all researchers must adhere to ensure sound ethical ad professional conduct, as well as respect for the rights of participants. These principles include confidentiality and respect, beneficence and non-maleficence and justice.

3.7.1 Confidentiality and respect

When I decided to approach the community of Congolese immigrants in South Africa, before giving any further information on the date and venue of focus group discussions, the potential participants were asked if they were willing to participate in the study. Those who agreed to participate were given a consent form, where the same principles and purpose of the study were mentioned in writing. The participants had to sign the informed consent form prior to participating to the present study.

Furthermore, in term of the confidentiality principle, in the present study, all the participants were not asked to disclose their identity, nor any other personal information during the study either. During the focus group discussions, they were each given a number and they were called using those numbers allocated to each participant. For instance, the participants were referred to as being participant 1, participant 2 and so on.

Before the beginning of each focus group session, all the participants were informed about the reason why the study was being conducted: I clearly told the participants that the data collection was for a master's dissertation. The informed consent form signed by each participant prior to every focus group discussion also had all the explanation regarding the

purpose of the current study. Participants were advised to take part in the study out of their own free will. Those who changed their mind about taking part in the study were free to withdraw from the study at any stage.

For instance, in one of the sessions, one of the participants clearly stated that he was not knowledgeable enough concerning mental health challenges. He then decided that he would not be a suitable candidate and withdrew from the study. There was also another Congolese immigrant living in Johannesburg who heard about the study from another friend. He then contacted the researcher and when told about the process, in other words, the focus group sessions, the gentleman clearly stated that even though the topic seemed interesting and relevant, he did not have time to just come and sit to answer questions in a group. He would have preferred to answer to all the questions over the telephone, individually. However, the researcher mentioned that the research design was about collecting data by organising focus groups. The gentleman ended up not taking part of the study, his position was respected and there were no negative consequences for not participating in the study.

3.7.2 Beneficence and non-maleficence

During the data collection process, none of the respondents was hurt physically or offended psychologically. They were asked questions related to their cultural understanding and help-seeking behaviours regarding mental health challenges. Those who mentioned the need for counselling or seemed to need professional help were given toll free helplines for free telephonic counselling.

Another aspect that shows that the present study followed beneficence is that the present study will empower the participants more about mental health challenges and rectify any misunderstanding previously held, in case there is any. Getting the right information from the participants will benefit the community, in a sense that their needs can be addressed base on the outcomes provided during the study (Terreblanche et al, 2006).

Results from this study has the potential to contribute to improving mental health policy in the Democratic Republic of Congo, other developing countries and recipient countries who offer refuge to immigrants and asylum seekers.

By respecting the non-maleficence, personal experiences from participants were not made public or were not used against them under any circumstances. If necessary, debriefing sessions with the help of professional therapists was planned.

Finally, during the focus group discussions, I kept on asking all the participants were comfortable with the questions and if they wanted to carry on. This was a way to ensure that all the participants were at ease.

3.7.3 Justice

In the present study, all the participants answered the same questions and the researcher provided the same conditions. They were all greeted; I introduced myself and I gave the informed consent form to all. The purpose of the study as well as all the required information was shared with all the participants, and none of the participants received any special treatment.

3.7.4 Transferability

Since Bhugra (2004) mentioned similar challenges shared by immigrants, the present study can be applicable to immigrants living in different areas. Even though the study is about exploring the cultural understanding and help-seeking behaviours of Congolese immigrants living in South Africa regarding mental health challenges, it is important to understand that Congolese immigrants do not only live in South Africa. There are thousands of Congolese immigrants in the United States of America, Europe and other parts of the worlds.

Since the present study focussed on a subgroup of those who grew up in the Democratic Republic of Congo and immigrated as adults, the results can be generalised to those Congolese immigrants living in different parts of the world, and other immigrant communities.

Furthermore, Congolese might have a different understanding and different help-seeking behaviours when it comes to mental health, but as Africans, they share similar cultural beliefs with those coming from different African countries. In other words, the current study may allow the understandings and help-seeking behaviours of those who are from Sub-Saharan Africa.

Finally, some cultures might be very different from those found on the African continent in general and in the Democratic Republic of Congo in particular, but there are phenomenon and reactions that are global. These include the stigma towards mentally ill patients, different understandings of mental health challenges and the way people see mental health challenges. Through the present study, it will be possible to generalise some findings and apply them to other populations.

This chapter has provided the rationale, research question and objectives, as well as detailed information on the research method, with regard to data gathering, coding and interpretation of the emerging findings. The next chapter provides an account of the emerging narratives from the data collection process.

Chapter 4: Presentation of the narratives

In this chapter, the group profiles and emerging narratives will be shared so that the reader can get a sense of the emerging dialogues. Secondly, the reflections and outcomes obtained from the focus group discussions for each category will then be collated and presented. Researcher observations on the various group dynamics are also reported.

4.1 Demographic summary of participants

The participants were divided into one pairing and five focus groups. The focus groups did not have the same number of participants. The number of participants in each support group ranged from two to six participants. Initially the focus groups were supposed to be made up of six participants on average. Unfortunately, in some sessions, participants cancelled their attendance at the focus group sessions at the very last minute.

4.2 Focus group narratives

4.2.1 Paired conversation 1

The first focus group session took place on Friday 27th May 2016 at 17:00. The chosen venue was the Acts Christian Church in Johannesburg, and more precisely in Midrand. The respondents both live in the Johannesburg area.

Table 1: Paired conversation 1

Number of participant	Age	Gender	Location and duration	Year of immigration
Participant 1	26	F	6 years	2010
Participant 2	26	F	6 years	2010

Average group age: 26 years and average number of years of immigration: 6 years

The first paired conversation was made from two participants who were both in their mid-twenties and have been living in South Africa for six years. Both participants have been living with family members of family friends who are Congolese immigrants. Both participants belong to the same church. They heard about the research when one of my friends approached them to find out if, as Congolese immigrants, they would be interested in taking part in the research. There were four other participants who were supposed to be part of the focus group, but they cancelled their attendance a few minute before the scheduled meeting.

With the two participants, there was a rich and full interaction as both participants had enough time to share their experience and views in details. Both participants are from the same age group. Even though they did not have the same experience as immigrants, they could relate to each other's situation. Every now and then, each participant was finishing each other's sentence, or nodding when one of them was answering questions.

4.2.1.1 Experience as immigrants

The two participants stated that immigrating in South Africa did not cause any traumatic experience, since they both believe that even if they stayed in Congo, applying to university and adjusting from adolescence to adulthood would still be overwhelming. However, the two participants said that being overwhelmed during immigration is not enough to trigger any mental illness. Therefore, both participants did not need a special strategy to cope because they both did not experience anything overwhelming.

"I cannot say that immigrating itself brought something that required special coping skills. Even if I stayed in my country, every now and then, I would have faced similar challenges. These challenges are part of the life of an adult, it is quite normal" (Participant 1).

Participant 2 then added the following statement: '*growing up comes with responsibilities. Leaving high school and starting a new life at university is stressful, no matter where you are. So, even if I stayed in the Democratic Republic of Congo, I would have also experienced stress one way or another. So, I can't really say that when I'm stressed, it's because I'm an immigrant. Even South Africans who live here in their own country are also stressed for the same reasons that make me stressed out''.*

While participant 1 mentioned the importance of the fellow community members during stressful processes such as application and settling down in a new city, participant 2 mentioned learning as part of the process as an immigrant.

"I was not alone during the process. I was living with relatives who at some point, were in the same situation as me. I was constantly asking for advice and guidance. Most of the time, everybody was willing to help. Even emotionally, it helped to know that there were people who were understanding and were encouraging me".

The second participant then added: "*I agree that the community always help. However, there is always something you will learn on your own during the whole process. As immigrants, we face similar challenges but at some point, we have specific experiences. We learn during those processes. As much as people are willing to help and advise you people will not be available all the time to hold your hand; people have lives and other responsibilities. That is why personally, I had to learn and discover while going through all the required tasks. Asking for help is good, but being strong and learning is crucial at some point".*

Following the last answer, there was a moment of silence and no more statements were made by both participants.

4.2.1.2 The understanding of mental health challenges

Both participants explained mental health challenges as invisible disorders that one cannot identify without being an expert and one of the participant mentioned that in her opinion, a mental illness is a disease that prevents one form functioning to their full capacity, and who are unable to make sound decisions.

"You can see some people who have irrational thoughts, they seem normal but you know that when discussing a serious matter, you cannot rely on those people's opinions or views, that is how you know that they are suffering from a mental illness"(Participant 1).

The second participants had a slightly different definition by stating the following: *"a mental illness is a condition where you notice that the person cannot function normally or make sound decisions.''*

4.2.1.3 The influence of the South African culture on the understanding of mental health challenges

When it comes to the influence of the South African culture on the understanding of mental health challenges, both participants clearly said that they have never heard anything being said about mental health challenges on campus or in any of their classes. However, they mentioned movies, or people in the neighbourhood, or their colleagues' family members who have suffered from a mental illness. The first participant stated the following:

"I've never heard the word mental illness in any of my classes"; "I've heard the word depression or mental health challenges on campus, but certainly not in class"; "mental health challenges are never mentioned at school".

"I hear more about mental health challenges in South Africa, compared to when I was living in Lubumbashi (Congo).However, I still don't know much. I know that mental health challenges exist, but I don't know anything about the causes, symptoms, consequences and even the different mental health challenges".

"Living in South Africa has not changed my understanding regarding mental health challenges because even though I have heard more about mental health challenges here in South Africa than in Congo, I only hear people talking about depression or bipolar disorder in an informal way, I don't get the detailed information, so I still don't understand mental health challenges completely''.

One of the participants mentioned that church was the place where she heard depression being mentioned very often, when the pastor invites church members suffering from mental health challenges in general and depression in particular to come forward in order for religious leaders to pray for them.

The second participant added her view after the first participant by making the following statement:

"I sometimes hear the pastor, at the end of the service, asking for people affected by depression or anything traumatic to come forward for prayer, that is also one of the moments when I hear the word depression, but I have never heard another mental illness being mentioned".

The first participant mentioned hearing about mental health challenges on television. She then added that she had heard about depression, bipolar disorder and Alzheimer's, without knowing how different those diseases were from one another*: "sometimes, I would watch a movie or any other program and hear Alzheimer's, depression, bipolar disorder and so on, I just know they are mental illnesses and not what they mean. And living in South Africa did not change my understanding."*

Even though the participants mentioned earlier that they could not clearly differentiate different mental health challenges such as bipolar disorder and Alzheimers, they claimed that they believed that mental health challenges were more prevalent in South Africa, because they have heard about mental health challenges more frequently in South Africa.

The participants then gave examples of other circumstances that allowed them to hear about mental health challenges.

*"At church, depression is brought up a lot during the sermon, where people are encouraged to seek help, maybe because many people here are depressed"(participant 2).*Following this statement, the first participant reacted by saying: *"Maybe here in South Africa people mention mental illnesses more often, that is why we hear people mentioning depression often. It does not mean that there are more mentally ill people in South Africa"* (Participant 1).

The participants then nodded and I moved to the next question regarding the presence of people facing mental health challenges in their community.

4.2.1.4 The presence of people affected by mental health challenges in the Congolese community

When asked about the presence of people suffering from mental health challenges in their community, both participants said they did not know any. However, one of the participants stated that there could be some, but since mental health challenges are not usually spoken about, those community members would not share that information with other community members.

"One of our neighbours was very slow, well, as a child I never knew what that was, but now that we are talking about mental health challenges, I think that he could be suffering from one

of the mental illness. I can't tell which one, off course, but I'm just suspecting" (Participant 1).

Before answering this question, the second participant smiled and said: *"I don't know anyone. Actually, I think they would be proud and not tell people they have a mental illness, so I'm not surprised why I do not know anyone. Maybe those I know who are suffering from any mental illness are hiding it"* (Participant 2).

4.2.1.5 Opinion toward people with mental health challenges

The participants were also asked what they believed about those suffering from mental health challenges. The first participant said that since there is a diagnosis in place to identify those illnesses, mental health patients are just like those suffering from common illnesses such as malaria or cancer.

"Since all those illnesses have a name and doctors can diagnose and differentiate them, I guess they are normal medical conditions that need medical attention."

The second participant, on the other hand said that those suffering from mental health challenges were weak, since everybody in this world, one way to another goes through times, but there is only certain people who sink into depression or need to see a psychiatrist. She then made the following statement: *"some people just overdo it, how can you end up in hospital for being extremely sad?*

Both participants raised their eyebrows and no further comments were made. I then moved to the next question.

4.2.1.6 Help-seeking behaviours regarding mental health challenges

When asked about their help-seeking behaviours, the second participant, who answered first, said she would take a mentally ill patient to church in order for a healing prayer.

"Praying is the key. Since it is hard enough to understand mental health challenges, only God can heal a mentally ill person".

The first participant mentioned mental health professionals as the best option to receive treatment: "*by going to the hospital, the patient can receive the treatment suitable to his medical condition, and maybe can get better. But I think that it is better to get medical attention and pray about it too, since mental health challenges are invisible.''*

She then added that the advantage of seeing medical professionals will allow those patients to receive the treatment that is appropriate to their condition. Participant 1 then added that combining medical treatment and prayers could help, by making the following statement: *"why not combine both methods? Seeing doctor and go to church or see a pastor. What matters at the end is being healed".*

No further comments were made, and I moved to the next question.

4.2.1.7 Suggested solutions to address mental health challenges better in the Congolese Community

Both participants believe that there is not enough shared information on mental health challenges. That is why, according to the first participant: *"people do not understand mental health condition and therefore, choose to either judge them or make assumptions based on what they see or believe, and you can't really blame them".*

"It's easy to mention the stigma around mental health challenges. However, mentally ill patients are often victimised because their family members or community do not understand their condition".

The second participant seemed to agree with what the first participant because she was nodding while the first participant was talking. She then added the following statement*: "When you see someone talking to themselves or behaving in a strange way, it's easy to judge them. The only way to understand them is to know what they are going through, why they are behaving that way and after knowing what is wrong with the person, you will know if they can be cured and function normally''.*

The need for improved information will address the victimisation and the current judgemental attitudes because of the lack of knowledge about mental health challenges. Finally, because both participants believed that being stressed and overwhelmed was normal and it was not

necessarily a trigger for mental health challenges, taking personal responsibility was also another recommendation the participants they made. They believed that people had to be brave in order to overcome challenges.

4.2.1.8 Dynamic of the group

Both participants were from the same age group, and were both females. They share the same hobbies, go to the same church and are student. Their lifestyle is quite the same. Even though as individuals they have different views, they also have shared the same challenges.

4.2.2 Focus group 2

The second focus group session took place on Saturday 28th May 2016 at 10 am and the chosen venue was the Public Library in Sandton, Johannesburg. The five male respondents all live in the Johannesburg area.

Table 2: Focus group 2

Number of participant	Age	Gender	Location and duration	Year of immigration
Participant 3	29	M	9 years	2007
Participant 4	25	M	6 years	2010
Participant 5	29	M	9 years	2004
Participant 6	25	M	6 years	2010
Participant 7	25	M	5 years	2011

Average group age: 26.6 years and average number of years of immigration: 7 years

The second focus group was made up of five participants. All the participants from this focus group attended a university in South Africa. Two of the participants were living on campus and the rest of the participants were sharing accommodation with fellow students from diverse cultural backgrounds. In those communes, there were South Africans and Gabonese citizens.

Participant 5 saw the social media posting and decided to share. The other participants then came forward. They had friends in common with the participant who first saw the post on the research.

This group also provided detailed information on the questions asked. However, they had the tendency to say: *'I think the same as the one who just answered'*. In order to avoid having a dull and repetitive conversation, I encouraged all the participants from this group to make statements. Even though they shared the same opinion as other participants, they were encouraged to mention that specific opinion, in their own words.

4.2.2.1 Experience as immigrants

All participants admitted that immigrating in South Africa was a bit traumatic at first. However, they all believed that it was not traumatic enough to cause any mental illness.

"I remember being terrified to walk on the streets of Johannesburg, after everything I have heard regarding the crime in South Africa. Being lost, not being very fluent in English was among the most challenging parts of my experience as a new immigrant. But with time, I got used to life in Johannesburg (participant 3).

Once participant 3 mentioned the few challenges, others started mentioning more challenges they faced as new immigrants. Those challenges included:

Getting used to the academic system in South Africa. Other statements made by other participants included*: "I had to figure out how to get my qualifications translated and evaluated by the South African Qualifications Authorities(SAQA).It was a process completely different from what we had back home, so It was frustrating. But it helped to have people from the Congolese community who had to do the same process, so fellow community members were helping with advice".*(participant 4).

Looking for a place in a secure suburb.

"When you are a young immigrant and a student, agencies are reluctant to make you sign a contract. They ask for proof of income and they battle to get foreigners 'criminal records because foreigners on temporary visas use passports and do not have South African Identity numbers. It can then be frustrating so we either get someone who has a job to sign the lease

for us, or we negotiate by providing solid proof that we will be able to afford the place. So, there is always a solution'' (participant 5).

Crime in some areas:

"We all know that Johannesburg is a dangerous city. However; not being able to speak any of the local languages makes it more difficult. In some areas, when you only speak English, you are seen an outsider, and it makes things more difficult. Considering that we find ourselves on the streets very frequently, it used to be frustrating in the beginning. But with time, we got used to it, and as foreigners, we know where to go, and which areas we have to avoid" (participant 7).

Opportunities not accessible to foreigners.

Some internships and scholarships are not allowed to foreigners: 'That is also one of the reminders that we are in a foreign country. There are opportunities, but at times we are limited. Well, we don't really moan about that because it is quite normal, some privileges are meant for nationals. Just like voting. We just take advantage of what is available for us, as foreigners.''(Participant 6).

Finally, participant 7 added that challenges and stress were normal but did not see how they have to turn into a disease: *"who gets a mental breakdown for not being able to find accommodation or after being rejected at university.''*

The men from this group did acknowledge all the challenges and had admitted that adapting, learning a new language and applying at university were challenging and stressful. However, the common point is that they had the tendency to point out that they coped with the challenges associated with immigration because they were brave and they therefore managed to overcome all obstacles they faced as immigrants.

Once all the participants shared their views regarding their experience as immigrants, I moved to the next question.

4.2.2.2 The understanding of mental health challenges

The participants were then asked what they understood by mental health challenges:

Once again, one after the other, each participant made different statements*: "We often see people on the street who are dirty, eating from trash, talking to themselves and behaving in a way that is beyond normal. For instance, some of those people walk long distances talking to themselves, smile to strangers, tell jokes to people on the streets, those people are definitely not normal. Since the condition does not seem physical, it can only be mental. Therefore that is what a mental illness is"* (Participant 3).The other participants' views followed the first statement:

"A disease that happens in someone's head." In other words, when someone cannot explain what is wrong with him, while he is not well and cannot think clearly, he can be considered as someone who is suffering from a mental illness"(Participant 4).

*"When you're just sick, unable to explain what is wrong with you, and no visible symptoms, then we can only conclude that you have a mental illness"(*Participant 7).

"When you have symptoms that are similar to someone who has been using too much drugs and start behaving in a weird way, it's definitely a mental illness". (Participant 5).

"You cannot really explain a mental illness: When you know that someone is sick but his disease does not make sense. It's when you just know that someone is sick, but you cannot explain what that person is suffering from"; it's a disease that keeps on coming back despite a previous recovery; it's a chronic illness but that is not visible"(Participant 6).

4.2.2.3 The influence of the South African Culture on the understanding of mental health challenges

When it comes to the influence of the South African culture on the understanding of mental health challenges, one of the participants mentioned television being the platform where mental health is often discussed. The following statement was made: *'personally, I hear about mental illnesses when I'm watching television. No one taught me about mental illnesses in South Africa or on the street*" (Participant 5)

Following that statement, the other participants started mentioning popular television programs or shows where a character was suffering from a mental illness or a television show where mental health challenges were once the topic of one of the episodes. The participants mentioned the popular series "*Empire"* where one of the characters suffers from a bipolar disorder (Participant 3). Furthermore, participant 4 mentioned "*Desperate Housewives"* with a character that was in a psychiatric hospital; participant 6 and 7 mentioned the Dr Phil show and the Oprah Winfrey show respectively, which have had guests suffering from mental health challenges every now and then.

But then participant 3 added another point, stating that those programs were not South African, *"yes, I agree, all those programs mentioned by the other participants do mention mental health challenges, but they are not South African programs. Even back home those programs are broadcasted. However, maybe we are older now and we are able to understand the story lines better than when we were kids… why being exposed to those programs while we are adults give us a better understanding".*

Following the statement made by participant 3, two participants did not mention any program in particular but mentioned that when watching the news, mental ill people are mentioned every now and then. One of the participants brought up the Oscar Pistorius trial, when there was a theory that the famous athlete was suspected of suffering from General Anxiety Disorder (GAD).

*"Recently we have watched a few high profile people in South Africa committing murder. One of those cases includes the Oscar Pistorius murder trial. During the trial, mental health challenges came into the picture" (*participant4). Participant 6 shared this view, and added facts since participant 4 knew about the Oscar trial vaguely.

Participant 6 mentioned the fact that people mention stress and depression quite frequently in South Africa: *"not a day goes by without hearing the word stressed or depression. It is difficult to draw the line between depression as a normal phase or the real disease. By hearing everyone saying I'm so stressed, burned out, I tend to repeat that too, because it's so common in South Africa, but I don't think I know more about mental health challenges simply because I'm now living in South Africa".*

Following that statement, there were more comments from other which included: *'I have to admit that even though living in South Africa has not taught me a lot about mental health challenges, I can easily tell someone that I am experiencing a burnout, because here people understand burnout, almost everyone gets it here, and it is acceptable. Back home, I would not have been able to mention suffering from a burnout, because my friends and colleagues would have laughed at me''* (Participant 3).

"Everybody is depressed, stressed or traumatised in this country. I cannot say that I have learned much about mental health challenges, but I just know that suffering from mental illness is normal in South Africa''(Participant 7).

Once everyone provided answers on this question. I asked the participants if they had anything to add, before proceeding to the next question

4.2.2.4 The presence of people affected by mental health challenges in the Congolese community

When asked about the presence of people suffering from mental health challenges in their community, two of the participants stated that they do know a few people who seem to have limited cognitive ability. Even though nothing has been said publicly, they suspected those community members suffer from mental health challenges.

Participant 3 claimed that he knew a young Congolese lady who started hearing voices. Even though he did not know which diagnosis she was given, he was aware that the lady was taken to Helen Joseph Hospital in Johannesburg for treatment.

Following the third participant's statement, other participants also shared their views:

"I remember a gentleman who used to live in the same street as us, back home, in Kinshasa. He used to stand on the street, even when it was extremely hot, talking to himself; even when having conversations with fellow community members, he was not making sense and people used to create debates just to see him talk without making sense and laugh at him''(participant 5).

"Now that we are talking about mental health challenges, who knows if we have friends who suffer from mental health challenges, but we don't know it''(Participant 6)

*"I think there are mentally ill in our community, but I don't think those diagnosed with a mental illness will disclose their diagnosis. That is why we don't know mental health patients" (*Participant 4).

Participant 7 said that he did not know anyone and could not think of anyone in his community with a mental illness. Following the silence after participant 7's answer, I thanked the participants for their input and I moved to the next question

4.2.2.5 Opinion toward people with mental health challenges

Following the question on the understanding of mental health challenges, the participants were also asked what they believed about those suffering from mental health challenges.

Before answering the questions, two of the participants laughed and then all five members started mentioning words such as:

Attention seekers – *"They just want their loved ones to fuss over them and get special treatment. "They just want attention, especially ladies, or an excuse to justify their failure, in case they are not successful, and it's easy to blame it on a mental illness."(*Participant 7)

Lost cause - *"I don't think those suffering from a mental illness can be given responsibilities or some tasks because they are so fragile that every time, you must wander if the mental illness is going to interfere with their daily lives''*(Participant 3)

Crazy - *"They don't think straight, for me they are not different from crazy people we see on the streets''* (Participants 4 and 6) who seemed to share the same view in this regard, by finishing each other's sentences.

One of the participants, on the other hand said that they were just like any other patients: *'If some are out there suffering from a mental illness but we are not aware of that, it can only mean that there are people who can function despite their mental illness. So they are just like anyone"* (Participant 5)

4.2.2.6 Help-seeking behaviours regarding mental health challenges

When asked about their help-seeking behaviours, two of the participants mentioned a combination of prayers and medical attention.

"Both prayers and medical attention seem important, especially if we don't know the cause of the mental health challenges. If the person has developed a mental illness as a result of drug abuse, medical attention is required, but if the person has been bewitched, it is important to pray for that person because only God can cure a disease caused by evil spirits"(Participant 5).

Participants 4 and 7 mentioned intense prayers or exorcism since, according to those two participants, mental health challenges can occur as a result of witchcraft, or when people go to *sangomas* in order to become more successful or to make more money. Following those two views, participant 3 added the following:

"If the loved ones suspect that their brother's illness does not have a natural cause, then they need to take him to church for prayers."

Finally, one of the participants said that one just needs to get over the feeling of depression and not make a "big deal" out of it: *"I don't know about other mental health challenges but when it comes to depression, being happy is a choice; someone can decide to be more positive and just move on, regardless of the situation"* (Participant 6).

That was the last comment on the last question from the interview. There were no further comments made. I then moved to the next question about the solutions to address mental health challenges better in the Congolese community.

4.2.2.7 Suggested solutions to address mental health challenges in the Congolese community

The group, as a whole believe that people are still clueless about mental health challenges because it is considered as a taboo. If communities were more empowered, they would have been able to take the matter more seriously and maybe help those affected by mental health challenges better.

*"You can see that we are laughing while talking about mental health challenges, maybe it's wrong, you know, because these are illnesses that are a burden to many. But like we said, we know that they exist, mental health challenges are real, but not only we do not understand fully the causes, symptoms and treatment process, we can only rely on what we see and on the myths, which are not always the correct information"(*Participant 6).

The fourth participant added the supporting following that statement,: *"I think I would have been more understanding if I knew what mental health challenges were all about, maybe I would have looked at mental health people with a different eye".*

4.2.2.8 Dynamics of the group

Despite the fact that all the participants did not know one another on a personal level, they all attended the same university and arrived in South Africa around the same time. The fact that they were all males also explained the similarity of reactions regarding certain questions.

This specific group had the tendency of underestimating the severity of mental health challenges, and claim that in South Africa, people tend to exaggerate on the severity of any stressful situation. Given the male dominance in this group this be the reason why their views revolved around trying to be braver and underestimating mental illnesses. Possible explanations to the reactions from these participants will be provided later.

4.2.3 Focus Group 3

The third focus group session took place on the 5th June 2016 at 18:00. The chosen venue was a participant's home in Randburg, Johannesburg, and all the participants live in Johannesburg.

Table 3: Focus group 3

Number of participant	Age	Gender	Location and duration	Year of immigration
Participant 8	30	F	26 years	1990
Participant 9	60	F	22 years	1994
Participant 10	36	M	22 years	1994
Participant 11	28	F	22 years	1994
Participant 12	31	F	15 years	2001

Average group age 37 years. Average number of years of immigration: 21.4 years

This group was more diverse in terms of ages in the group, having one pensioner while the other four group members were a lot younger. What they have in common is that the younger participants said they were all raised in South Africa and the pensioner raised her children in

South Africa. Participants from this group have been living in South Africa for more than 20 years.

Two of the participants are a married couple. They also heard about the research when one of their friends shared the announcement on social networks. They then contacted fellow Congolese immigrants. When attending a funeral, the couple mentioned the research, and the other participants came forward since they seemed interested. They all live in the same neighbourhood.

The conversation from this group was totally different from the previous groups, because one of the members was diagnosed with clinical depression, and the same participant was on antidepressants, as a treatment for her condition.

4.2.3.1. Experience as immigrants

Four of the participants barely remembered the time they immigrated since they were very young when they arrived in South Africa.

However, one of the participants who is a pensioner remembers that time, but stated that she came with her husband, who found a job prior coming to South Africa; so, she admitted that everything went smoothly for her family when they immigrated.

"*My husband found a job in South Africa, so the company took care of everything. I have six children. Our children were also very young, so it was easy for them to get used to their new environment. They enjoyed their new environment and I also enjoyed my new home, considering that I was not alone, I came with my whole family''* (Participant 9).

No further comments were made regarding the participants' experience as immigrants. I then moved to the next question, regarding the understanding of mental health challenges.

4.2.3.2 The understanding of mental health challenges

In this group, they all explained mental health challenges as emotional diseases and all had the tendency to associate mental health challenges with clinical depression. The following definitions were given during the discussion:

"When someone claims to be sick, and you can see that they are not doing well, losing weight and losing their appetite or usual happiness, one can easily see that there is something wrong. Since the condition is not physical in this case, it can only be a mental illness" (participant 12).

"When asking that person how they feel, sometimes they cannot tell you any apparent symptoms and even when going to the doctors, a blood test does not show that the person is sick. That can also be a mental illness" (participant 8).

One of the participants then started sharing her story: she went through a traumatic divorce and started suffering from chronic migraines, insomnia and when she went to see a doctor, she was diagnosed with depression.

The participant who was diagnosed with clinical depression and who is currently on anti-depressants stated the following when asked about her understanding of mental health challenges:

"Mental health challenges are conditions that happen after having a problem for too long. When someone feels drained, and is battling to cope with life. We are adults and we deal with many problems at all levels. There are times when it becomes difficult to cope with all those problems, so this can lead to depression or an emotional breakdown". (Participant 9)

She then added, based on her personal experience that she could not find peace, or comfort after her divorce. Because she was battling to sleep and was starting to have chronic headache, she went to see a doctor. She then added that before receiving the diagnosis, she did not know that depression was real, but then she added that she was a living proof that depression does exist. The other participants nodded and for a few seconds they all became emotional.

Participant 11 then looked at the lady who was diagnosed with depression and claimed: *"sometimes people do not acknowledge the existence of mental health challenges simply because they don't know anyone affected or they do not understand how severe and what the consequences were. I'm sure if mental health challenges was a topic everyone knew about, it would have been easy to talk about it, there would have not been stigma and denial''.*

The last statement was followed by a moment of silence. Since all the participants gave their view regarding their understanding on mental illnesses, I moved to the next question, on the influence of the South African culture on the understanding of mental illnesses.

4.2.3.3 The influence of the South African culture on the understanding of mental health challenges

When it comes to the influence of the South African culture on the understanding of mental health challenges, all the participants said that they basically spent most of their adult life and all they know about mental health challenges have been learned in South Africa. The following statements were made during the discussions:

"When we were at school, we had a school counsellor, and we knew that when having problems to cope, we had to see her."(Participant 12).

"I spent most of my life here; I learned all I know about mental health challenges here in South Africa. From what I know when feeling emotionally drained, it is normal to see a doctor or a psychologist. However, in the Congolese community, there are negative comments on mental health challenges, so I have to admit that every now and then, I'm trapped between both conceptions and I even wander if those mental health challenges really exist"(Participant 10).

"It's all in the head, I understand that mental health challenges exist, but the most severe cases are always found in the white community, and there must be a reason. Who knows? Maybe depression is more prevalent in the white community" (Participant 8).

"Even though I was being treated by a doctor in Congo for my depression, when I came here, being on anti-depressants and hearing a lot more about depression on television made me understand and accept my condition better" said the lady who was diagnosed with depression. But she added*: "even though I understand my condition, my family who have been living in South Africa for over 20 years are not aware of my condition. I have never said a word because I know that with us, Congolese, we do not understand these things. I will be judged"* (Participant 9).

Participants 8 and 10 also mentioned that when growing up, they have heard words such as depression, schizophrenia or bipolar disorder, not among Congolese but among friends from school, who either had a friend or family member affected by a mental illness.

Once all the views were shared, I moved to the next question, by asking the participants about the presence of people facing mental health challenges in their community.

4.2.3.4 The presence of people with mental health challenges in the Congolese community

When asked about the presence of people suffering from mental health challenges in their community, four of the participants did not know any Congolese suffering from a mental illness and the fifth participant, as previously stated, was suffering from depression.

She was the first one to answer the question by stating the following; *"I am a living example that there are people with mental health challenges in the Congolese community*."(Participant 9).

Then other participants added the following:

"There might be some mentally ill patients in our community, but these are not the kind of things people discuss openly, especially with people who are not close to them"(Participant 13).Participants 8,10,11, and 12 did not know anyone in their community who had mental health challenges. Following the participants 'answers, I proceeded with the next questions, on the opinion towards mentally ill people.

4.2.3.5 Opinion towards people affected with mental health challenges

The participants were also asked what they believed about those suffering from mental health challenges.

"I feel sorry for them because it is hard to completely recover from a mental illness and you cannot really live a normal life when suffering from a mental illness'' (participant 8).Following this statement, participant 10 added another point: *"you might be a good person with many other qualities but once your mental illness diagnosis is known, you might just be seen as a freak. That's not what I think of mentally ill people, but at some point if society does*

not trust mentally ill patients, I have to do the same to protect myself. For instance, I cannot hire a nanny or an assistant that is suffering from any kind of mental health challenges''.

Participant 9, the lady who has been diagnosed with depression, added, while smiling: *"I completely understand what the other two people just said now. That is why I have hidden my diagnosis from my own family members. I know that people would have more compassion if they think that I am suffering from chronic migraines, then clinical depression. I will then be judged and I will be accused of looking for attention.''*

Participants 11 and 12 said they had a neutral opinion towards mentally ill patients. The researcher then asked them to be more explicit, just to understand their view more.

Participant 11 made the following statement: *"mental health challenges are something I only hear on television or from people who are not close to me. Therefore it's not really a phenomenon I have experienced in my family or amongst my loved ones. My opinion is based on the stereotypes I know. I just know that people who suffer from mental health challenges are unpredictable, dangerous and violent. To tell you the truth, I don't know if it's true but that is what I have learned through society".*

The last participant to comment was participant 12.She made the following statement: *"what makes this question difficult is the fact that someone who has been admitted for years for a serious condition cannot be compared to someone with milder forms of mental health challenges. Society tends to generalise, but I think that they are not in the same situation".*

"I could easily feel comfortable with someone who has a mild form of a mental illness but I would be scared of those with severe mental health challenges, in case they are violent".

Following this statement, I thanked the participants for the rich exchange and I moved to the next question, which was on help-seeking behaviours regarding mental health challenges.

4.2.3.6 Help-seeking behaviours regarding mental health challenges

When asked about their help-seeking behaviours, they all said they would take a mentally ill to hospital for treatment and also for a better understanding.

All the participants said that they know that there are psychiatrists, psychologists and counsellors who are more equipped to deal with the treatment of mental health challenges. Mental ill patients should then be taken there for treatment.

"I would take them to the hospital, because if there are people there who understand what is wrong with the person, it is better to send them somewhere they can get suitable treatment"(Participant 10).

Participant 9, who was diagnosed with depression, emphasized the importance of social support in the recovery process:

"I understand the importance of seeing a mental health practitioner, but as far as I'm concerned, I would have preferred to have my family's support. They know that I'm sick, but couldn't disclose my mental illness and sometimes it hurts me. The minute I mention all those problems that make me drained emotionally my acquaintances always tell me to move on, and they all ask me to pray. Yes, I believe in the power of prayers, but I'm under the impression that no one understands me''.

Following this statement, two more participants shared their views regarding the chosen help-seeking behaviours regarding mental health challenges: *"We are not equipped to know what goes into a mentally ill patient's mind, that is why we just react based on what we believe, but they are sick, and need help"* (Participant 12).

"The reason why going to the hospital when suffering from a mental illness is that not only the patient will be treated, but the patient will also know more about the condition"(Participant 11).

Those statements include all that was said in this group regarding the chosen help-seeking behaviours regarding mental health challenges. I then moved to the next question.

4.2.3.7 Suggested solutions to address mental health challenges better in the Congolese Community

When asked about what can be done to improve the situation regarding mental health challenges, the participant who was diagnosed with depression mentioned that her family was not aware of the diagnosis. She added that if all her family members knew, they would judge

her and would not be supportive. However, she said that it would have helped if her children knew that she was suffering from depression since she feels that every now and then she needs that support.

"When you live isolated, it is easier to sink into depression".at least when living in a strong community, with people who care about you, it is easier to forget about some of your daily problems and smile again" (Participant 9).She then added: *"Loneliness can increase the risk of depression"; when there is no one who is there for you, it is easy to lose your mind". She therefore believed that the Congolese community needs to be educated and given facts about mental health challenges. The other participants suggested education and programs that empower communities and provide tools to understand mental health challenges better and prevents stigma regarding mental ill people"*

Participant 8 also shared her view regarding the best way to address the management of mental health challenges in the Congolese community *"As soon as one person mentions something like anxiety or burnout, the same colleagues who understood your stress level will start looking at you differently. They will tell you straight to your face that you are trying to act like a white person. They will even call you a coconut".*

Following that statement, participant 12 added the following view*: "You will be accused of being westernised. Or simply to try to live a lavish lifestyle, since depression is seen as a disease of rich people who can afford to go "moan "about their problems to a therapist".*

Following that, participant 9, the lady who was diagnosed with depression added: "*even though in our community people tend to say that mental health challenges are more for white people, what does it say about me? I am Congolese but I was diagnosed with depression. They can say that there are more white people affected by depression but I don't think that I'm the only Congolese person suffering from depression. So I agree that more need to be done, in order to empower communities, to know more to allow those who are either suffering from depression or who have loved ones affected by any mental illness to deal with those mental health challenges the right way".* The same participant added: *"things are changing; people are travelling and are living among different communities. While people are not only imitating hairstyles and other habits, seeking therapy can be done, if they realise that in the western culture, seeking counselling is normal when dealing with emotional problems.*

However, the fear to be made fun of can prevent that. People need to understand the importance of counselling and what mental health challenges are really all about. It will help people, not only in the corporate world, but in our Congolese communities too. Praying and to remain connected to the community was also a suggestion from the participants, as a way to prevent mental health challenges from arising.

No further recommendations were made, that is where the discussion ended with this focus group.

4.2.3.8 Dynamics of the group

Unlike all the preceding groups where the participants seemed to joke about mental health challenges, the participants from this group did not make a lot of dismissive or negative comments. One of the explanations could be the presence of someone who was diagnosed with depression. They were probably trying to be sensitive toward the lady who was directly affected by mental health challenges.

4.2.4 Focus Group 4

The fourth group session took place on Sunday 12th June 2016 at 1 pm. The chosen venue was one of the participant's homes in Pretoria. The four respondents are all based in the Pretoria area.

Table 4: Focus group 4

Number of participant	Age	Gender	Location and duration	Year of immigration
Participant 13	41	F	7 years	2009
Participant 14	45	M	10 years	2006
Participant 15	32	M	10 years	2006
Participant 16	28	F	9 years	2007

Average age of the group: 36.5 years Average number of years of immigration: 9 years

The fourth focus group was made of 4 participants. All the participants in this group have been living with family members.

Two of the participants were my brother's friends. The two other participants were neighbours. When they were approached, regarding taking part in the study, they seemed interested and they decided to take part in the study. However, none of the participants knew one another before the focus group session.

With all the participants from this focus group, there was a rich interaction. They had one thing in common: they all lived with family members who are also Congolese immigrants.

4.24.1 Experience as immigrants

They a mentioned some of the struggles that they have faced in their home country, the Democratic Republic of Congo, and realised that living conditions are better in South Africa.

Two of the participants, which include participants 13 and 16, added that people living in South Africa tend to complain about anything and want everything handed over to them.

Furthermore, additional comments were made in this regard*: "people love using the word stress; everything is always blown out of proportion. It is normal to be overwhelmed but to turn it into a disease is a bit exaggerated"* (participant 15).

One participant added the following statement: "we *can never separate stress from everyday life, we just live with it, and it does not have to turn out to be a disease. All the participants claimed that mental health challenges are not really part of the black culture. It is more a western problem* (Participant 16).

Participant 14, who seemed to agree with the preceding statement, added the following*: "we don't know all those diseases, it's for white people. We are all depressed at some point in our lives, but getting out of it is a choice."*

Following this statement, the participants did not add anything else. I then moved to the next question, on the understanding of mental health challenges.

4.24.2 The understanding of mental health challenges

The participants were then asked what they thought about mental health challenges. These were the answers given by the participants:

"Conditions that affect people's emotions"; "When someone cannot think in a rational manner" (Participant 13)

"When someone is not able to cope with life problems"; "People with a level of intelligence below the normal level" (Participant 15).

No further comments were made. After thanking the participants for their contributions during the interview, I moved to the next question.

4.2.4.3 The influence of the South African culture on the understanding of mental illnesses

When it comes to the influence of the South African culture on the understanding of mental health challenges, the participants had different views. One of the participants stated the following:

"I see things differently in South Africa. If there is help, why suffer in silence. If doctors see that whatever you are suffering from is a mental illness and can get a suitable treatment, why not? Back in the days, when I was in Congo, I used to think that every time they mention a mental illness, the patient is bewitched. But here I see many people being treated from mental health challenges by western medicine. I cannot say that I understand more about mental health challenges, but I see that there are things I did not know" (Participant 13).

There was a slightly different opinion from two participants 15 and 16: *"the cause of the illness is important to decide on which treatment approach to use. If there is a spiritual cause or another reason no one understands, it is better to take the patient to a church or a pastor".*

It's not about being in South Africa or in the DRC. If you have a mental illness because of witchcraft then prayers are needed. So I was not influenced by South Africa (Participant 15).

Participant 14 claimed not being influenced by the South African environment in her knowledge regarding mental health challenges.

With no further comments made, I moved to the next question, which was based on the presence of people with mental health challenges in the Congolese community.

4.2.4.4 The presence of mentally ill people in the Congolese community

When asked about the presence of people suffering from mental health challenges in their community, all the participants said they did not know anyone in their community with a mental illness. None of the participants expanded or made statements. I then moved to the next question which was based on the participants' opinion regarding those affected by mental health challenges.

4.2.4.5 Opinion toward people with mental health challenges

The participants were also asked what they believed about those suffering from mental health challenges.

They all believed that mental ill patients are weak and are just looking for an opportunity to get sympathy from other people. The following statements were made:

"They are people who are not making any effort to get out of their misery, they enjoy being depressed and maybe they think that people will feel sorry for them" (Participant 15).Participant 16 nodded while this statement was made and added: "*I completely agree.*

The participant 13, added that since everybody in this world, one way to another goes through times, but there is only certain people who sink into depression or need to see a psychiatrist. Finally, the last statement came from participant 14:*"we all have problems and as humans we must be able to cope. Those who lack the ability to cope with daily struggles are those who sink into depression, so they are weak".*

No further comments were made after that. I thanked the participants for their contribution and I moved to the next question, which was based on the help seeing behaviour regarding mental health challenges.

4.2.4.6 Help-seeking behaviours regarding mental health challenges

When asked about their help-seeking behaviours, the participants said that they should take a break from anything overwhelming them, or pray for their condition, in case it is a spiritual problem. Participant 15 was the only one who said that since there are professionals who are equipped to treat those conditions, they should be taken to hospital.

Finally, the participant 13 made a comment regarding the choice of treatment: *"I have seen or heard about South Africans suffering from mental health challenges. That means that mental health challenges are real.*

However, personally, the participants admitted that they do not know much about mental health challenges. That is why they might seem non-supportive towards mentally ill patients. Any treatment that cures or help the patients should be chosen, as reflected in the response,. *"I am not familiar, but whether it is though medication or traditional healing, what matters is to be healed" (*participant 13).

Since no more statements were made, I then moved to the next question regarding the suggested solutions for the management of mental health challenges.

4.24.7 Suggested solutions to address mental health challenges better in the Congolese Community

The participants were asked about strategies to address the problem, regarding mental health challenges in their community. Different statements were made in this regard. Those statements included *"If communities stop discriminating mental ill patients, people will be encouraged to go to hospital for help. But if they are seen as crazy, they will not be encouraged to seek medical attention when having symptoms of a mental illness"* (Participant 13).

"Mental health challenges are not the same; some are more serious than others. While some mental health patients are violent and dangerous, others are not. But we are not equipped to see who is dangerous and who is not. That is why we generalise all mental health patients" (participant 16).

"We need to know more to help our fellow community member more" (Participant 15).

Following those recommendations, the participants were thanked for their participation and their rich contribution.

4.2.4.8 Group dynamics

There were both males and females and different age groups. The answers were not very different, as the participants from this group shared the same challenges and realities. The diverse demographic information did not appear to influence any aspect of their responses.

4.2.5 Focus Group 5

The fifth group session took place on the 18th June 2016 at 15h00. The chosen venue was a hair salon in Yeoville, Johannesburg, as all five respondents live in the Johannesburg area.

Table 5: Focus group 5

Number of participant	Age	Gender	Location and duration	Year of immigration
Participant 17	35	M	7 years	2009
Participant 18	25	M	5 years	2011
Participant 19	32	F	6 years	2010
Participant 20	31	M	8years	2008
Participant 21	26	M	5years	2011

Average age of the group: 29.8 years Average number of years of immigration: 6.2 years

The fifth focus group was made of five participants who came from different socio-economic backgrounds in the Democratic Republic of Congo. Two of the participants were working in a hair salon. The remaining three were clients from the same hair salon. When I approached them; they seemed interested in the research and decided to take part in the study. Two of the participants had made contact with me, and that is how the support group session took place.

4.2.5.1 Experience as immigrants

The two participants stated that immigrating in South Africa did not cause any traumatic experience, since they both believe that even if they stayed in Congo, they would have still been stressed by the political instability, the constant inflation and so on.

"I'm an adult, by deciding to move to a foreign country, I had to know how to work hard, and it is also part of one's journey in life. Even though I can ask questions around me, I need to keep in mind that there are challenges I have to face by myself and no one will be there to hold my hand"(Participant 17).

"In our country, we hustle to survive. The majority of the population in the Democratic Republic of Congo is unemployed. Yet, we survive. It's never easy but we don't have a choice. In this country, people love complaining, that is why people love make stress seem like a disease. It is normal, and eventually, it goes away, there is always a solution to any problem" (Participant 18).

Following this comment, one participant added: *"We come from a country with no existing social grant, no basic services and no free medical treatment and so on. In other words, we have been raised to fight to get what we need and to provide for our children"* (Participant 21).

Four of the participants, including participants 17, 18, 19 and 21 claimed that mental health challenges are not part of the Congolese community. In their opinion, the DRC has been going through a difficult time, and Congolese could afford depression or suffering from a burnout. However, participant 20 stated that his older brother, who lives in Johannesburg, was hijacked at his home early this year. The whole family was present during the hijacking. He had to organise some counselling sessions for his children. The participant added that following the hijacking, the children were shaky and were certainly traumatised. However, his older brother did not want to go for counselling, since he said that he is able to cope with the trauma on his own.

Following this answer, participants 17. Said that the children needed counselling because children who live in South Africa are weaker and cannot handle stress.

The disagreement between those views almost led to a heated debate. However, I have asked the participants that there will be a question where they would be able to expand more on their view. I then moved to the next question, on the understanding of mental health challenges.

4.2.5.2 The understanding of mental health challenges

The participants had then to answer the question on what they understood by mental health challenges:

Participant 20 said: *"disease caused by too much burdens"*. Following this statement, other participants mentioned the following statements:

*"Hearing voices and having hallucinations" (*Participant 17)

"Illnesses that make someone want to commit suicide" ;(Participant 18)

*"Diseases that have symptoms similar to someone who is possessed" (*Participant 19)

"Diseases that happen as a result of excessive drug abuse or; any excuse someone uses when struggling to deal with personal problems" (Participant 21).

Once all the answers were provided, I thanked the participants and I moved to the next question, regarding the influence of the South African culture on the understanding of mental health challenges.

4.2.5.3 The influence of the South African culture on the understanding of mental illnesses

When it comes to the influence of the South African culture on the understanding of mental health challenges, once again, there were different views among the participants:

"I never paid attention to mental health challenges before quite frankly. But when I saw my nephews traumatised and in need for counselling in order to cope, I have realised that trauma is real. I don't know much about other mental health challenges, but I think that it is the same thing, those diseases are real. Once you see someone going through this, you realise that they are real" (Participant 20).

But there was a different view following the first participant's answer: *"the system in this country allows people to be weak and claim to be traumatised for the most insignificant incident. Back home we could not afford to have a burnout and stay in bed. We have seen it all, back home from shootings, war and other stressful situations but our kids grew up fine. The same participant added, this time talking to the one who answered previously: "you just mentioned that your brother did not go for counselling, and he was fine. And his wife, even though she was a bit shaken, she did not go for counselling either. But the children had to see a psychologist because they were not coping. That is why I said that your brother is like you and I, we grew up in an environment that forced us to be tough while these kids who were brought up here are weaker"* (Participant 19).

The two participants had a heated conversation, since the first one did not like it when the other participant mentioned weakness, and he felt that his family members were referred to as being weak because they had to go for counselling after being hijacked.

Eventually, I had to intervene by saying that examples were welcome but it was more about the issue of mental health challenges and the culture in addressing the problem in general in the Congolese community.

"I understand more, one of my South African roommates suffered from depression, she even stopped classes and went back home, even though I don't understand how depression can be so severe" (Participant 21).

Following this answer, participant 21 added: *"we do not know depression in our country, not to the extent that we see here. You can get sad, but sooner or later you have to move on; I thought that depression could be cured automatically, with time, after relaxing or doing any pleasant activity".*

No more comments were made, and the answers were becoming repetitive. I then moved to the next question, on the presence of people with mental challenges in the Congolese community

4.2.5.4 The presence of people with mental challenges in the Congolese community

All the participants' except participant 20 responded negatively with regard to knowing people experiencing mental health challenges. When asked to be more explicit, one of the ladies added: *"With mental health challenges being medical conditions like any other ones, it means that there must be mentally ill patients in our community too. However, I know that it is some kind of taboo to reveal that your daughter, son, partner has psychotic episodes or suicidal tendencies. Therefore, those who might suffer from those mental health challenges do not disclose their diagnosis or symptoms in the community"* (Participant 17).

Participant 21 held a different view: *"yes I agree that people who hide any diagnosis or symptoms related to mental health challenges in their family. However, I believe that when you pray for those illnesses, someone can be healed. So I believed that those who have noticed problems related to mental health challenges and decided to pray for it have been healed, that is the reason why we do not find people with mentally ill people in our community".*

There was then another opinion shared by participant 19 as following: *'We are stronger mentally. In our country everything is a struggle. I don't think there is anything else here that can make you have an emotional breakdown. We can get depressed but we always manage and I don't even think that medication is needed to treat what affects your emotions'.*

Participant 18 claimed that he does not think mentally ill people are present in the Congolese community here in South Africa. If someone cannot work or function, I think their family members would send such a person back to Congo. *"Who is going to feed or pay rent for someone who is constantly showing signs of instability? I believe that if we can find mentally ill people in the Congolese community, you will find them wandering the streets back home. Not here".*

Finally, participant 20 mentioned his nephews who had suffered trauma after being hijacked at their home. No more additional comments were made and I moved to the next question regarding the opinion toward people affected with mental health challenges.

4.2.5.5 Opinion toward people with mental health challenges

The participants were also asked what they believed about those suffering from mental health challenges. That question once again generated a heated debate because two of the

participants did not agree with the view of people being weak because they are suffering from a mental illness.

Participant 19 claimed that those suffering from a mental illness such as depression are just those people who are trying to imitate the western lifestyle. The other participants, following this claim stated that depression and emotional breakdowns are not part of the Congolese culture.

Participants 20, on the other hand, whose nephews received counselling admitted that mental health challenges existed, but he said that here in South Africa, the context is slightly different since one can go to a psychiatric clinic and get treatment while in Congo, the same patient would be laughed at by fellow community members. Other answers linked to mental health challenges included:

Weak –"There is a choice to snap out of depression, but those affected by mental health challenges don't try harder to get out of it''(Participant 21).

Bewitched - "Nowadays, it is difficult to get a job or to be successful in life. People tend to go to sangomas to get money and power. But as a consequence, some become crazy and we see those signs as mental health challenges'' (Participant 18).

Unstable- "Not only mentally ill patients are violent and dangerous, there cannot be trusted enough to give important responsibilities because you never know when they are going to have a mental breakdown'' (Participant 17).

People who are misunderstood - "Not only that mentally ill people are all put in the same category, people judge them according to myths, while they are just as sick as any other patients suffering from visible diseases''(Participant 20).

Following the answer provided by participant 20, I moved to the next question, regarding the help-seeking behaviours regarding mental health challenges.

4.2.5.6 Help-seeking behaviours regarding mental health challenges

When asked about their help-seeking behaviours, four of the participants, including participants 17, 18, 19 and 21 said she would take a mentally ill patient to church in order to

receive a healing prayer. One of the participants believes that praying and medical treatment should be combined. The following statements were made:

"Yes, those diseases exist, but they are all in the mind, only prayers can cure mental health challenges" (Participant 19).

"With all the problems back home, we would have all been depressed, but we are not, because we cannot afford to be depressed"(Participant 21).

"We are tough, depression is for people who are weak and who do not believe in God" (Participant 19).

"You cannot be a child of God and be depressed" (Participant 17).

"Praying and worshiping makes depression goes away" (Participant 18).

The different answers share the same explanations as the one from the previous sections, with a negative perception linked to separation, perception linked to spirituality linked to not knowing the cause of the illness and finally a positive perception to integration or assimilation.

Following the different help-seeking behaviours they would choose to treat mental health challenges, the participants were asked about the solutions they would like to see to address the gaps in mental health within their community.

Participant 20 shared his view and mentioned the use of medical facilities to manage mental health challenges: *"since there are facilities to treat those mental health challenges, we need to know more in order to use them if needed. The little we know, the harder it will be to seek medical attention for mental health challenges''.*

Participant 21, who initially added the following view: *"It is important to know whether those mental health challenges can be cured completely or if they are chronic conditions. I think that patients are also judged based on that. If we knew and were sure that once a person is being treated, they can get back to their daily activities and pout their mental illness behind, they would not have been judged so much''.*

No more statements were made and I moved to the next question regarding the suggestions to address mental health challenges in the Congolese community.

4.2.5.7 Suggested solutions to address mental health challenges better in the Congolese Community

Finally, when it comes to the solution to the problem, once again, the participants all believed that there is a need for education and accurate information regarding the origin and treatment of mental health challenges. The stigmatisation of not being strong enough and judgemental attitudes will need to be addressed by such a psycho-educational programme.

4.2.5.8 Group dynamics

The participants from this group were different from the previous participants. They were not university students or people who were facing challenges related to academic and educational challenges.

These participants came to South Africa to look for better opportunities. Their situation did not influence the results differently, as their experience was similar to the participants who faced challenges similar to immigrants in general.

The participant who had family members affected by trauma seemed more sympathetic than the others, who believed that in South Africa, there is an exaggeration regarding stress and mental health challenges in general.

4.2.6 Focus Group 6

The sixth group session took place on the 20th June 2016 at 15h00. The chosen venue was a hair salon in Rosettenville, and all the respondents live in Johannesburg.

Table 6: Focus group 6

Number of participant	Age	Gender	Location and duration	Year of immigration
Participant 22	39	F	9 years	2007
Participant 23	35	F	11 years	2005
Participant 24	40	M	10 years	2006
Participant 25	60	F	8 years	2008
Participant 26	35	F	5 years	2011
Participant 27	41	F	15 years	2001

Average age of the group: 41.7 years
Average number of years of immigration: 9.67 years

The sixth focus group was made of five participants, they all attended tertiary education in Congo. All the participants in this group were customers from a Congolese hair salon in Rosettenville, Johannesburg. This group produced a lot of interaction and various answers came from the rich conversation.

4.2.6.1 Experience as immigrants

The participants stated that immigrating was stressful, but not enough to trigger a nervous breakdown.

Furthermore, the participants mentioned relying on community members for guidance and help regarding all the processes all immigrants go though. These include: permit renewal for some or asylum seeker process for others as well as application for scholarships, jobs or just for admission at university. Several comments were made to explain the experiences as immigrants:

"I had to ask people who went through the same experience as me, by being an immigrant" (Participant 22).

"It helps to get a few pointers from those who went through similar situations and faced the same challenges as the ones you are about to face, as a new immigrant" (Participant 23).

"In South Africa, there are hundreds of thousands of Congolese immigrants(laugh).You will always find a cousin, a former classmate, a neighbour or anyone who is either related to you or to a friend. In other words, you will always find acquaintances or relatives who can give you advice when settling in your new home" (Participant 24)

"I lived with relatives who had either friends or roommates; this allowed me to ask them questions regarding my situation. I knew that most of those people from my community faced the same challenges I was exposed to when I arrived to South Africa" (Participant 25).

"*As hard as things can be, in our community it is very likely to find someone who went through the same challenge as yourself. In my experience, when I came, I was neither she nor embarrassed to ask around, about those who had to translate their qualifications, apply to universities and colleges. I was given different tips and it helped a lot*

Those tips I received were not 100% what I used when applying and looking for accommodation, but it gave me an idea on how things were done in South Africa" (Participant 26).

"The best way to succeed is to network with people who share the same goals with you. For instance, if you spend time with those who are not planning to study in South Africa, they might be immigrants like you but they will not be able to give you the right information regarding the application process. Those who have tried and failed in the past may even discourage you by only pointing out the negative side of the whole process. The same goes for those who come with the intention to go on the job market straight away. Only those who did the same or planning to do the same can help you in the right direction.

So, even though I did rely on the community for advice and guidance, it was important to me to identify those who would have been helpful to my specific needs" (Participant 27).

4.2.6.2 The understanding of mental health challenges

When asked what they understood by mental health challenges, the participants described mental health challenges using the following terms:

- *"A disease that no one can control"*(Participant 22)
- *"A disease that happens in someone's head* (Participant 23),

- *Where you cannot really identify the symptoms but you can just see that the person is sick"* (Participant 24).
- "*A disease where someone has reduced cognitive ability: "Usually, mentally ill patients are those struggling to learn or at school in general"* (Participant 27).
- *"A disease where someone cannot function properly: "Mentally ill patients are unable to make sound decisions"*(Participant 25)
- Diseases that make someone become dangerous or violent: *"They hear voices, they have imaginary friends, they talk to themselves and they live on their own planet"* (Participant 26).

Following those definitions provided by the participants, I moved to the next question, about the influence on the South African culture on the understanding of mental health challenges.

4.2.6.3 The influence of the South African culture in the understanding of mental health challenges

When it comes to the influence of the South African culture on the understanding of mental health challenges, the participants said yes, but for different reasons:

"My child was diagnosed with attention deficit hyperactivity disorder (ADHD). Living in South Africa allowed me to understand the condition better and to help my child. If I was still living in Congo, I have to admit that I would have still be in denial and therefore not supportive towards my child. So I can say that living in South Africa has taught me a lot regarding this specific illness" (participant 27).

She then added *"Yes, in South Africa, doctors find it normal to prescribe anti-depressants, which you can find easily. If that treatment works, why not, mental health challenges are normal, we tend to believe otherwise because we don't know much".*

"We don't really have depression and trauma or stresses as a medical condition in our country, the only depressed people I know are white. Maybe depression exists but we either hide it or deal with it without medication or therapy. But it's important to remember that we are Africans and we need to toughen up when in distress".

Besides participant 27, all the other participants claimed that living in South African did not influence their understanding on mental health challenges.

Following that question, I moved to the next one, where participants were asked about the presence of mentally ill people in their community.

4.2.6.4 The presence of people with mental health challenges in the Congolese community

When asked about the presence of people suffering from mental health challenges in their community, five participants said they did not know any. However,

One of the ladies from this focus group has a child who was diagnosed with Attention Deficit Hyperactive Disorder. The participant grew up in the Democratic Republic of Congo but is raising her child who is in primary school in South Africa. When she was called at the school by one of the teachers, she was informed that her child was suffering from ADHD and the child needed treatment.

Participant 27 then started sharing her story by explaining what happened when she found out about her child being affected by ADHD*: "I looked at the teacher and asked him: 'what is that disease? We do not know such things in our country. Where did my child get that? Is that contagious? All the kids in my family are normal, I have plenty of nephews and nieces, and none of them has this problem. But my child was born here, maybe she is just like South African children then, she thinks like South African children, maybe that is the reason why she caught a disease that is more prevalent in this country''.*

Following participant 27 comment, I thanked the participants for their contribution and I moved to the next question, regarding the opinion toward mentally ill people.

4.2.6.5 Opinion toward people affected by mental health challenges

The participants were also asked what they believed about those suffering from mental health challenges.

One of the participants said that even though it is not usually mentioned in the Congolese community, mental health challenges are medical conditions. *"It doesn't matter what we believe or what we know about mental health challenges, as individuals. The fact is they are*

real conditions. So those affected by mental health challenges are patients, like anyone suffering from other medical conditions (Participant 22).

"What makes those diseases difficult to understand is the fact that they are unpredictable and they change the patients 'behaviours" (participant 23).

Participant 27, the ladies whose child was diagnosed with ADHD admitted that before getting treatment for her child, she believed that mental health challenges were serious and her child would have been unable to function and would even be living like a disabled person. But after talking to the doctors and getting all the required treatment, she has realised that she overestimated the severity of the illness. She then concluded that mental health challenges are the same as any other medical conditions.

Following the view shared by participant 27, I moved to the next question, regarding the chosen help-seeking behaviours regarding mental health challenges.

4.2.6.6 Help-seeking behaviours regarding mental health challenges

When asked about their help-seeking behaviours, one of the participants said she would take a mentally ill patient to church in order to receive a healing prayer, just in case the mental illness is caused by witchcraft (participant 22).

Participants 27 mentioned mental health professionals as the best option to receive treatment, one of the ladies took her child to a psychiatrist for a full assessment and she claimed that it was a fruitful journey since it allowed her to be part of her child's treatment, even though she does not understand how her child got that disease. She then added that the advantage of seeing medical professionals will allow those patients to receive the treatment that is appropriate to their condition.

All the other participants, who include participants 23, 24, 25, mentioned that having both medical treatment and prayers would be more suitable for the patients, due to the fact that mental health challenges are unpredictable and not easy to manage.

Following this shared view I moved to the next question, regarding the suggested solution to address mental health challenges in the Congolese community.

4.2.6.7 Suggested solutions to address mental health challenges better in the Congolese community

All the participants believe that there is not enough education on mental health challenges. Training and educating people on mental health challenges could make a significant difference.

After completing this focus group session, the researcher realised that there were no additional information being provided. In other words, saturation was reached and no other group were added for the present study.

Once again, the answers from this group, like in the previous group discussions, can be explained by the overestimation of the participants in-group by claiming that mental health challenges are not part of the Congolese culture and on the other hand, integration as a way to explain those finding normal to be using medical treatment.

4.2.6.8 Dynamics of the group

The participants from this group showed the same characteristics of the other groups. That is why I have decided to end with the focus group discussions since there was nothing new.

One of the common observations was the fact that the participants, who knew someone who was directly affected by a mental health condition, were more understanding. In this particular group, the lady whose child was diagnosed with ADHD had less judgemental comments, even though she admitted that at first she did not understand why her child was affected by a mental health condition.

All the others had the tendency to find mental health burdens, and that view did not differ according to their age group or gender.

4.2.7 Formative observations

The age of the groups did not appear to have any influence on the answers regarding the cultural understanding and help-seeking behaviours of Congolese immigrants living in South Africa.

From the emerging results, those who showed a significantly more positive view regarding mental health challenges were those who were either affected directly or indirectly, by having a loved one who has been affected. For instance, the lady who was diagnosed with clinical depression had a different view because she has been receiving treatment for depression herself. The participant who had relatives who went for counselling after an armed robbery also believed that mental health challenges are real. The lady whose child was diagnosed with ADHD also believed that those conditions exist, even though she stated that back home she had never heard of anything such as ADHD.

The group with only male participants showed a great tendency to underestimate mental health challenges. Even though during the other focus group sessions, many participants mentioned that stress was normal, those from the second focus group even laughed about it, as if it was really unbelievable to have people suffer from mental health conditions because of stress.

Chapter 5: Thematic interpretation of the findings of the study

In this chapter, the themes that emerged during the focus group discussions will be collated and analysed according to the structured categories prepared in the semi-structured interview schedule for facilitating the focus group conversations. The findings of the study will then be compared to the pertinent issues from the literature reviews, and will be interpreted accordingly.

The table below shares a full profile of the participants from the study for ease of reference. Restricting the sample to the convenient location of Gauteng, for financial reasons, undermined the generation of a full profile and more comprehensive understanding of the lived realities of the sample within the entire country. Furthermore, no distinctive differences were reported for respondents living in Johannesburg or Pretoria, the two residential sites.

With regard to the notion of the age variable as used during this study, no significant differences were reported from the various age groups. In addition, the duration of immigration does not appear to be a significant variable in the acculturation process either, as no distinctions were found across the groups based on the years of immigration to South Africa. It might be that a decade, given that the average number of years since immigration is10.37 years, is too short a period to really examine lived experiences in stages.

Table 7: Collated participant profile

Participant number	Age	Gender	Location and duration	Year of immigration
Participant 1	26	F	Jhb: 6years	2010
Participant 2	26	F	Jhb: 6years	2010
Participant 3	29	M	Jhb: 9years	2007
Participant 4	25	M	Jhb:9 years	2010
Participant 5	25	M	Jhb: 6years	2010
Participant 6	29	M	Jhb:9 years	2004
Participant 7	25	M	Jhb:6 years	2010
Participant 8	30	F	Jhb:26 years	1990

Participant 9	60	F	Jhb: 22 years	1994
Participant 10	36	M	Jhb:22 years	1994
Participant 11	28	F	Jhb:22 years	1994
Participant 12	31	F	Jhb:15 years	2001
Participant 13	41	F	Pta:7years	2009
Participant 14	45	M	Pta:10 years	2006
Participant 15	32	M	Pta:10 years	2006
Participant 16	28	F	Pta:9 years	2007
Participant 17	35	M	Jhb:7 years	2009
Participant 18	25	M	Jhb: 5 years	2011
Participant 19	32	F	Jhb:6 years	2010
Participant 20	31	M	Jhb:8years	2008
Participant 21	26	M	Jhb:5years	2011
Participant 22	39	F	Jhb:9 years	2007
Participant 23	35	F	Jhb: 11 years	2005
Participant 24	40	M	Jhb:10years	2006
Participant 25	60	F	Jhb:8 years	2008
Participant 26	35	F	Jhb:5 years	2011
Participant 27	41	F	Jhb:15 years	2001

Average age of the participants = 33.88 years
Average number of years since immigration =10.37 years

The emergent data for the various categories are now reported:

5.1 Category 1: Coping strategies as immigrants

When the participants were asked about the way they have been coping as immigrants, the following salient themes emerged: turning to fellow community members for support, stress being part of everyday life, immigration as a new experience and structural change.

5.1.1 Turning to fellow community members for support

When the participants were asked about their coping strategies after immigrating, one of the common answers was turning to fellow community members for support. This common tendency from the participants can be explained by the fact that individuals from sociocentric societies tend to turn to their community for support.

According to (Bhugra, 2004), sociocentric societies put the needs to the whole community first. Furthermore, people from sociocentric communities tend to rely on their community for support. African communities, coming mainly from sociocentric types of communities. Those participants who mentioned turning to their community members as a way to cope with immigration were convinced of getting help since individuals from sociocentric communities tend to focus on the whole community's problems, and are prepared to enagage.

These findings are also supported by Ngcobo and Pillay (2008) who have also mentioned that community support is popular among some communities. Social Identity Theory, which was used as a partial framework for the study, can also explain why the Congolese immigrants rely on their community for support. Presented by Turner (1979) Social Identity Theory explains individual cognitions and behaviour with the help of group processes. Furthermore, Social Identity Theory prunes the solidarity between people sharing the same group.

In the present study the Congolese are all members of a same group and therefore relying on one another can be explained by Social Identity Theory.

Finally, since the previous study is also focusing on immigrants and how acculturation can influence the understanding and help-seeking behaviours regarding mental health challenges, using the principles of acculturation can also allow us to understand why the Congolese immigrants rely on their community for support. Bhugra (2004) as well as Bhui et al (2005) have mentioned that with immigrants being in contact with a new culture, acculturation will take place.

However acculturation, discussed in previous sections of the dissertation, has different levels with one of them being separation. According to Ndika (2013), when separation occurs, immigrants keep their own culture without adopting the new culture. In this example, relying

on the support from community members is more about wanting to cope with people sharing the same challenges and culture.

5.1.2 Stress is part of everyday life

Another frequent statement from the participants regarding their coping strategies after immigrating in South Africa was that stress was part of life and did not require any special strategy to overcome challenging situations. This is how the participants' opinions can be explained: Ngcobo and Pillay (2008) stated that in some communities, being overwhelmed by life problems is quite normal and therefore, people just have to deal with everyday problems.

When moving to a foreign country, one must expect some of these challenges. In some communities, stress is seen as being part of everyday lives. That is why in those communities, stressful situations are not linked to mental health challenges but to something a human being can deal with and heal from automatically (Ngcobo and Pillay, 2008).

Ellis et al (2010) shared the same views when their studies revealed that in some communities, even though people acknowledge the existence of mental health challenges like depression, the same people believe that one can just recover automatically, since diseases like depression can be part of everyone's life. This explains the view from the participants who claimed that stress is part of everyday life and does not have to turn into pathology.

Social Identity Theory, once again can be used to understand these findings: according to Tajfel and Turner (1979) maximising the in-group success tends to reinforce individuals 'self-esteem. During the focus group discussions, for instance, some of the participants made comments by saying that people in South Africa tend to exaggerate the concept of stress .That is an example of an individual undermining the out-group, and maximising his in-group ability to cope with stress effectively. Generally too, the respondents made comparisons between the resource-constrained situation in the DRC and a totally different context in RSA, to reinforce their notions of survival and resilience.

5.1.3 Immigration as a new experience

Finally, another statement emerged during the focus group discussions regarding their coping strategies. The participants mentioned considering immigration as a new experience rather

than an overwhelming process. They actually feel grateful about the resources available in South Africa.

This is how their view can be explained: When having a closer look at the socioeconomic aspect of the Democratic Republic of Congo, Ganasen et al (2008) mentioned the scarcity of healthcare in general and psychiatric ones in particular. People often have to rely on the informal sector to earn a living and the same community struggle to get quality healthcare.

With one psychiatric clinic in the capital city of the second largest country in Africa, (Kashala et al (2005) have mentioned that community members have to rely to pastoral counselling and their community for distress. However, as mentioned in previous sections, it is important to note that relying on pastoral counselling or any alternative methods of management of mental health challenges is not only due to the lack of resources but also to belief systems. Rathod et al (2017) claim that mental health challenges are highly driven by the beliefs held.

In the context of Congolese, the political instability in the country has had heavy consequences on the country in general and the healthcare system in particular, as mentioned by Kohli et al (2012). With inaccessible quality healthcare for those who are from the low socio economic background, communities have felt helpless over the years. That is why the participants claimed that the struggle to settle in is not an unknown phenomenon. When they were living in their home country, they have acknowledged relying on the informal sector to survive.

Burke (2009) has explained that according to Social Identity Theory, individuals have the tendency to enhance their group's performance. In this case, the Congolese immigrants mentioned that despite the challenges, and the lack of basic services in their home country, they have managed to cope with stressful situations.

5.1.4 Structural challenges

Some of the structural challenges mentioned during the focus group discussions include the language exclusion from the participants whose first language is French, accessing finances and finding accommodation and so on. These structural challenges are the same as the ones mentioned by Bhugra (2004) who has also listed the same challenges as the ones faced by immigrants.

These are some statements made by some participants during the discussions that explain structural challenges: *"When you are a young immigrant and a student, agencies are reluctant to make you sign a contract. They ask for proof of income and they battle to get foreigners 'criminal records because foreigners on temporary visas use passports and do not have South African Identity numbers. It can then be frustrating so we either get someone who has a job to sign the lease for us, or we negotiate by providing solid proof that we will be able to afford the place. So, there is always a solution''* (from focus group 3).

"We all know that Johannesburg is a dangerous city. However; not being to speak any of the local languages makes it more difficult. In some areas, when you only speak English, you are seen an outsider, and it makes things more difficult. Considering that we find ourselves on the streets very frequently, it used to be frustrating in the beginning. But with time, we got used to it, and as foreigners, we know where to go, and which areas we have to avoid" (from focus group 3).

"Some internships and scholarships are not allowed to foreigners; that is also one of the reminders that we are in a foreign country. There are opportunities, but at times we are limited. Well, we don't really moan about that because it is quite normal, some privileges are meant for nationals. Just like voting. We just take advantage of what is available for us, as foreigners.''

Those structural challenges, once again have made them feel excluded from their new environment while reinforcing their social identity as Congolese, which, as explained by Turner and Tajfel (1979), cited in Burke (2009), has enforced ties with their community. Innovative, even though subversive, ways have been reported as to how the respondents overcome these challenges.

5.2 Category 2: Understanding of mental health challenges

During the focus group discussions, when the participants were asked what they understood by mental health challenges, the following definitions were provided: a disease that happens in someone's head, a disease one cannot explain, diminished cognitive functions, people unable to make their own decisions, a disease crazy people suffer from and depression.

5.2.1 A disease that happens in someone's head

This definition can be explained by the direct translation of the way mental illnesses are explained in some vernacular languages. Ngcobo and Pillay (2008) has explained this situation, with words such as depression which, in some vernacular languages in Kenya were translated by "pain in the chest".

5.2.2 A disease difficult to explain

According to Bavojdan et al (2011), mental health challenges are often associated with external factors. This is usually the case with a phenomenon human beings struggle to explain completely.

Ventevogel et al (2013) conducted a study in order to understand mental health challenges in four different areas in Africa. The same study also aimed to find out what the people from those communities thought about the causes of mental health challenges. Two cities in South Sudan, one city in Burundi and finally, a city in the Democratic Republic of Congo were included in this study. Among the results of the study, all the areas in general and the participants from the Democratic Republic of Congo in particular, mentioned natural and psychosocial causes associated with mental health challenges. When somatic diseases such as malaria were the cause of mental health challenges, the participants could understand mental health challenges better. However, once the cause was linked to any psychosocial cause such as divorce, grief, rejection and rape, the participants could not explain the mental health challenges. That is when the participants claimed that those symptoms occur in one's mind (Ventevogel et al, 2013).

5.2.3 A disease crazy people suffer from

When defining mental health challenges, more than once, participants made the link between mental health challenges and homeless crazy individuals seen wandering on the streets.

As previously mentioned, the Ventevogel et al (2013) study in Butembo, a city on North Kivu, in the eastern part of the Democratic Republic of Congo, revealed that mental health patients were referred to as *musire*, with mental health challenges being called *erisire.* The

participants from the same study identified mental health patients to neglected people wandering the streets, wearing dirty clothes, talking to themselves and not making sense when trying to engage in a conversation. The answers from the current study shows consistency with answers provided by Congolese living in Butembo, one of the areas in the Democratic Republic of Congo.

Another way to explain this understanding of mental health challenges is the stigma around mental health challenges. According to Corrigan and Watson (2002), mental health patients are often portrayed as violent and unpredictable, with psychotic like symptoms. Psychosis is often associated with the following symptoms: confused thinking, false beliefs, hallucinations, changed emotions and disturbed behaviours (Ventevogel et al , 2013).That is why some participants tended to generalise mental health challenges with psychotic disorders.

5.2.4 Diminished cognitive functions

In Lingala, which is one of the official languages in the Democratic Republic of Congo, one of the terms used to describe mental health challenges is 'nerves'. So when translating, they would say someone has problems with his nerves. This explains why people with diminished cognitive ability are seen as mental ill patients.

Ngcobo and Pillay (2008) explained a similar situation with depression not having an exact translation in some African languages: In some cases, depression was simply translated by terms that mean "pain in the chest". By mentioning nerves as an explanation, the participants were associating mental health challenges with some kind cognitive disability. Dinos et al (2004) have also mentioned that individuals affected by mental health burdens such as psychosis were more victims of stigmatisation while those affected by mood disorders were victims of patronising attitudes from other community members. This explains why the respondents mentioned diminished cognitive functions as a definition of mental health challenges. This also shows that the participants who provided this definition generalised all mental health burdens, as described in the previous section.

Two participants believe that mentally ill patients are those who cannot make decisions on their own, and who behave in the most irrational manner. Those are people who cannot have a normal conversation with you, since their reasoning is not normal.

Following that answer, other participants added the following answers:

- People who are slow
- People who take long to understand or process basic information
- People who are extremely stupid

The answers provided by the participants during the current study show consistency with the ones provided when Ventevogel et al (2013) who examined people from Butembo, a city in the Democratic Republic of Congo, in order to investigate their understanding of mental health challenges.

5.3 Category 3: Impact of the South African culture on your understanding of mental health challenges

When asked whether the South African culture has influenced their understanding regarding mental health challenges, the participants either said no to any influence or mentioned just greater exposure.

5.3.1 No particular influence

Even though the participants mentioned not having a direct influence from the South African culture, the media in general and television in particular were mentioned as one of the most common ways they heard about mental health challenges.

However, the answers provided on their understanding of mental health challenges were mostly based on stereotypes, as mentioned by Corrigan et al (2012),who have mentioned stereotypes and stigmatisation as frequent amongst mental health patients.

5.3.2 The South African culture

Those who mentioned understanding mental health challenges better due to the South African environment were those who saw someone affected by a mental health challenge.

While most participants claimed not be influenced by the South African culture in their understanding of mental disorders, they kept on mentioning how children born here were more fragile and therefore, similar to South African children and young relatives. That is how a couple of participants explained how their children were diagnosed with mental disorders such as ADHD and trauma.

There were participants who also mentioned that Congolese children who grew up in South Africa were as fragile as South African children and more likely to develop mental health challenges. This statement, once again can be linked to Social Identity Theory where people from one group tend to undermine people from the out-group.

When explaining the findings according to acculturation, integration can be mentioned. Ndika (2013) defines integration as a step of acculturation where the immigrants keep their own values while adopting those of their new environment. In this specific case, integration has allowed those who had loved ones affected by mental health challenges to use coping strategies offered here like trauma counselling. More reflections on integration will be developed under the theme of help-seeking behaviours.

5.4 Category 4: Mental health challenges in the Congolese community

When the participants had to answer about the presence of mentally ill patients in their community, they were two themes that emerged: the participants either had no knowledge of fellow citizens being mentally ill or had people they suspected being mentally ill but they had never heard about a formal diagnosis of any mental illness in their community.

5.4.1 No one affected by mental health challenges

Through the focus group discussions, the participants revealed that the stigma was high in the Congolese community. On the other hand, the fact that most of the participants did not know about mentally ill patients in their community could be explained by the high stigma associated with admitting mental health challenges.

In some African communities, previous studies such as the one conducted by Ellis et al (2010), have revealed that people suffering from mental health challenges preferred going to see general practitioners and be treated for the somatic symptoms, rather than seeing a psychiatrist and disclosing their mental health diagnosis; Tomlinson et al (2009) have also supported the same claim. The reason for avoiding psychiatric services was due to the high stigma and consequences in the community. This is confirmed by Mantovani et al (2016) who claimed that due to the stigma toward mental health challenges, those affected were struggling to get jobs or to get accommodation. Patel et al (2007) also mention the stigma affecting people affected by mental health conditions. That is probably why, even though there could be some people affected by mental health challenges in the community, they do not disclose their condition.

Another explanation of the answers provided by the participants is that according to the results from a study conducted by Riolo et al (2005) a low prevalence of depression was found among African Americans because most African Americans were not seeking help for their depression. Furthermore in developing countries the similar findings have been shown, where a large number of people affected by mental health challenges do not seek help. Once again, as a result of stigma towards mental health professionals as mentioned by Becker and Kleinman (2013) or because of sociocultural beliefs, as discussed earlier.

Finally the fact that the participants constantly repeated that, as Congolese, mental health challenges were not part of their culture, can also be explained by the principles underlying Social Identity Theory. The participants wanted to use the Congolese culture in order to reject the high prevalence of mental health challenges. When individuals identify with their group, or the in-group, they tend to believe that the in-group is strong and efficient. In other words,

the group they belong to tends to be praised and successful situations are associated with the in-group (Burke, 2009).

In the present study, participants want to believe that their in-group, the Congolese community, is capable of managing mental health burdens well, without having those burdens turning into pathology. Their argument can also relate to the notion of social identification, which is one of the process levels of the Social Identity Theory. During the process of social identification, group members associate themselves with the group where they belong.

5.4.2 Presence of people with mental health challenges in the Congolese community

There were a few examples of the processes of integration from one participant who was diagnosed with depression and a couple of others, whose loved ones were affected by mental health challenges. As mentioned by Schwartz et al (2010), integration occurs when the immigrants keep their own values while adopting certain ones from their new environment. In the context of the present study, those affected directly, like the participant who was diagnosed with depression, or those affected indirectly like those whose loved ones had been diagnosed, seemed to find help in manner which is different from the kind of help-seeking behaviours they would have used in the DRC.

5.5 Category 5: Perceptions toward those suffering from mental health challenges

Following the presence of mentally ill patients in their community, the participants had to give their opinion on those suffering from mental health challenges. The following themes emerged during the focus group discussions: mental health challenges were a sign of weakness, witchcraft, sick like any other patient and attention seekers.

5.5.1 Weakness

Participants repeated more than once that being stressed or traumatised was part of everyday life. Furthermore, the participants believe that one can just recover automatically from a traumatic event. However, the participants believe that those who develop a mental illness are weak. As previously stated, participants mentioned that going through stressful situations is part of everyone's life but recovering from trauma and moving on was a choice.

Two participants mentioned the fact that some fellow black Congolese tended to behave like snobs. In other words, they spend more time with friends from Western backgrounds. They therefore start behaving like white people, and resort to mentioning conditions like burnouts, stress, and depression as medical conditions, while in the Congolese community, those phenomena are part of everyday life, and stressful situations come and go.

Associating mental health challenges to trying to behave like a white person can be explained, once again by the process of assimilation, which entails, according to Bhui et al (2005), means adapting to the new culture an individual is exposed to. In this specific example, the Congolese immigrant will be accused of being influenced by the western culture by finding mental health challenges normal, or by claiming to be depressed. Furthermore, as mentioned earlier, Dinos et al(2004) claim that people affected by mental health challenges such as mood disorders tend to be patronised by others. This tendency can explain why some of the participants see them as weak.

5.5.2 Witchcraft

One more than one occasion, participants associated mental health challenges to external causes in general and witchcraft in particular. Therefore, the participants consider those suffering from a mental illness as being bewitched.

From the study conducted by Ventevogel et al (2013), participants were asked about the causes of mental health challenges, and the responses stated were supernatural causes. In other words, the participants mentioned witchcraft as being one of the causes of mental health challenges.

This explanation shows, once again consistency with the results from Ventevogel et al (2013) where mental health challenges were very often associated to witchcraft in Butembo, a city in the Democratic Republic of Congo.

5.5.3 Attention seekers

When elaborating on witchcraft, and on the fact that mental health challenges are conditions that are invisible and difficult to explain, one can see how the participants linked mental health challenges to external factors.

According to Amuyungu-Nyangongo (2013), categorizing people with mental health challenges as attention seekers also results in the discrimination against mental health challenges. Furthermore, according to Ciftci et al (2013), people with mental health challenges are also victims of stereotypes. That is why, associating those affected by mental health burdens to attention seekers can just be a way of using stereotypes to avoid dealing with the issues.

5.6 Category 6: Chosen methods for improving the management of mental health challenges

The participants were then asked to mention the chosen method to manage mental health challenges. The following themes emerged: medical options, community support and prayers, and a combination of medical treatment and prayers.

5.6.1 Medical options

Ventevogel et al (2013) mentioned in their article that, people who were part of their research conducted in four different African communities, including one in the Democratic Republic of Congo, used western treatment for mental health challenges when they believed that the causes were natural for instance, when the mental illness occurred as a result of malaria.

This shows consistency with the results from the present study. The participants mentioned going to a doctor or the hospital as an option from treatment when drugs or the causes of the mental disorders were somatic or visible.

5.6.2 Community support and prayers

Even though it is not the same as medical treatment, talking to a religious leader like a pastor can help. Not only he can be a shoulder to cry on, but the pastor can actually assist with some counselling. Despite the presence of mental health challenges in both developed and developing countries, there are cultural views of mental health challenges in most African countries that do not encourage most people to seek treatment when experiencing symptoms of mental health challenges (Ganasen et al, 2008). Ellis et al (2010)have also mentioned prayers as one of the chosen methods for mental health challenges management.

With African countries being very religious, several communities link mental health challenges to supernatural forces. In other words, one affected by a mental illness is seen as being bewitched or controlled by an evil spirit. According to Amayungu-Nyamongo (2013), associating mental health challenges with evil forces can be explained by the fact that mental health challenges are not as straightforward as most somatic diseases.

As previously mentioned, community support is a way for Congolese immigrants to identify with other group members, as part of their social identity. Furthermore, with prayers having a very important place in the life of Congolese; using prayers reinforces their social identity and shared behaviour patterns.

Using prayers and their community for treatment, can be explained by the notion of separation. The latter is a principle of acculturation as defined by Ndika (2013), as the step where immigrants keep their own culture and reject the culture from their new environment. It is worth noting that for many other communities in South Africa this kind of strategy is also used for support.

Finally, Rathod et al (2017), have shared the example of India, where 90% of people affected by mental health challenges rely solely on their community. This example shows that community as a support system is important and the answers provided by the participants from the present study confirmed these previous claims.

5.6.3 Combining prayers and medical treatment

Finally, combining both medical treatment and community support was also a popular option among the participants. As previously mentioned prayers seem to play an important role in the management of mental health challenges, because according to Mantovani et al (2016), mental health challenges are often associated with witchcraft in certain cultures. Furthermore, with integration as a step in the acculturation process, those who have learned how to deal with mental health challenges using medical treatment adopt the South African culture with regard to managing mental health challenges while keeping the popular help-seeking behaviours, linked to their initial culture, being the prayers. As indicated this is not unique to the Congolese community though.

5.7 Category 7: Recommendations from the participants

The participants were finally asked to propose strategies to improve the management of mental health challenges in their community. The following themes emerged: the need for educational interventions for diverse groups and efforts to stop the stigma and its negative consequences.

5.7.1 Psycho-social educational interventions

According to Corrigan et al (2012), education campaigns to educate communities in the United States of America made a difference to the ways in which individuals understand mental health challenges. The results from the same study revealed that education and contact with mental health patients helped reduce the stigma against mental health patients. However, the results were different according to the age groups. Education and contact with mentally ill patients was efficient in reducing the stigma among adults, but among adolescents education was the only efficient strategy and contact with mental ill patients increased the stigma among adolescents. A different approach to engaging with and understanding mental health is indicated for younger people.

In this specific study, psycho-educational programmes could then be made available to the community. Corrigan et al (2012) used videotapes and movies as contents to educate communities, because those methods are cheaper and can reach a large number of people.

Ganasen et al (2008) has also mentioned the influence of mental health literacy in help-seeking behaviours. In other words, by educating people on mental health, they will know more about mental health conditions and might seek help when in distress. It will then prevent people, and even communities, experiencing symptoms of mental health challenges but not knowing where to go. As stated by Ngcobo and Pillay (2008), people spent five years before getting mental health treatment in South Africa, due to the fact that those patients did not know where to seek help from.

5.7.2 Breaking the stigma and associated consequences

In some communities, according to Amayungu-Nyamongo (2013), mental health challenges are associated with shame and dishonour. As a consequence, some people did not want to see

mental health professionals. Furthermore, some studies have revealed that in some communities, being diagnosed or associated to any kind of mental health challenges would simply cause rejection towards the patient from the community. Ciftci et al (2013) pointed out a very interesting cultural difference. On one hand African Americans and Asians considered those suffering from a mental illness as dangerous individuals while Latinos considered the same people to be less dangerous.

The following results show consistency with another study conducted among Somali refugees in the United States, who refused to use psychiatric services, fearing stigma in their community (Ellis et al, 2010). The stigma around mental health challenges, and the cultural silences, explains the reluctance from most people in general, and those from the present study in particular, to access and use psychiatric services.

Therefore, by educating people more, the stigma will be reduced and more people will seek treatment for mental disorders. Furthermore, fellow community members will also be more supportive and they will be more equipped to help mentally ill patients.

Chapter Five presented all the salient themes that emerged during the focus group discussions, and the themes were then analysed according to existing literature to verify or show deviances in the findings. The next chapter summarises the findings of the present study by revisiting the main research question and supporting objectives of the study.

Chapter 6: Layered meta-analysis of the findings

This chapter now provides an integrative account of the thematic findings in relation to directly addressing the research question and objectives of the study. The emerging positions have been aligned to the literature reviewed in this regard, to locate the outcomes of the present study in a meaningful manner.

The following research question was formulated as the touchstone for the study: *"Will the mental health understanding and help-seeking behaviours of Congolese differ according to the extent of the acculturation process while living in South Africa?"*

Five major objectives were set for the investigation to arrive at a deeper understanding of the main research aim, as follows:

1. To explore the understandings of mental health challenges in a sample of Congolese immigrants
2. To explore whether moving from the DRC to South Africa has influenced the cultural understanding of mental health challenges
3. To understand their coping strategies with regard to the identified stressors linked to immigration
4. To describe the preferred help-seeking behaviours
5. To generate recommendations for how the situation could be improved

6.1 Participants' understanding of mental health challenges (Objective 1)

The view from the participants regarding their understanding of mental health challenges was influenced by the fact that mental health challenges were relatively unknown and reported behaviours were rather generalised. When they were mentioning insanity for example, they tended to point out symptoms that resemble those affected by schizophrenia and other psychotic disorders. This undefined notion of craziness is often the core belief held by people, who tend to believe that all mentally ill people are aggressive and unpredictable (Corrigan & Watson, 2002).

The participants of the present study also associated mental health challenges to external factors, with an emphasis to: a disease one cannot explain, control or that happens in one's head. With external factors being mentioned, evil spirits were also considered to play a role in the existence of mental health challenges.

Mental health challenges were also associated with mental retardation: the view from the participants tends to think about mental illness as condition where the person affected could not function and live a normal life. Even though mental health challenges were generalised by the participants, different views were associated to the categories mentioned: insanity like condition, invisible illness no one can control or understand or retarded.

From the answers provided, the participants had a biomedical view of mental health challenges, where the mentally ill patient was victimized and judged as a result of his mental health status.

6.2 Acculturation and mental health challenges (Objective 2)

The media was mentioned as a source of information regarding mental health challenges: on one hand, some participants mentioned move characters and on the other hands, high profile cases on prime time televisions were perpetrators were mentally ill, or committed a crime as a result of their mental health status.

Once again, the stereotypes associated with mental health challenges played a big role in the perception towards mentally ill people, because, in movies, people with mental health challenges are often described as dangerous, violent and irresponsible.

One participant who was diagnosed with depression and a couple of participants who had loved ones affected by mental health challenges, mentioned that it was more a cultural problem, with people who have lived in South Africa. Because of the influence from their friends and South African colleagues, they are more likely to develop those mental health challenges or be affected by trauma to a point where medical attention would be needed.

By constantly mentioning that those growing up here would be weak like South Africans and more susceptible to develop mental health challenges, the participants' view supports a key notion of Social Identity Theory, as a way of enhancing the in-group performance while minimising the out-group performance (Burke, 2009). Therefore, they believe that as a

community, they are stronger and able to cope with mental health challenges effectively and are more resilient.

Acculturation did influence the understanding of Congolese immigrants regarding mental health. However, not all the participants were at the same level of acculturation. While some experienced integration, there were others who experienced assimilation, separation or marginalisation. The hypothesis was accepted, as acculturation did change the participants' view regarding mental illnesses. However, there were different levels of acculturation observed among participants.

The study therefore served to understand the effect of acculturation in the understanding and help-seeking behaviours of Congolese immigrants in South Africa. With Social Identity Theory as the conceptual framework of the present study, some aspects of acculturation found in the present study such as separation could also explain the findings from the present study.

For themes where participants reflected on separation, it shows how, Social Identity Theory, as presented by Turner and Tajfel (1979) highlights the way individuals categorise themselves as being part of one group and separating themselves from the out-group.

6.3 Coping mechanisms with stressors related to immigration (Objective 3)

The participants did acknowledge the existence of stress and anything that can disturb one's mental health, which shows consistencies with Ellis et al (2010) However, the participants had the tendency to find any stressful situation normal, and even believe in fellow community members for help, when challenges are present.

Considering stress as normal or something one can survive either automatically or with community support. This is consistent with some of the findings from previous research where it is believed that in some African cultures, stress is part of everyday life, and is not linked to anything pathological since individuals are expected to recover automatically (Ngcobo & Pillay, 2008).

Jacob (2013) also mentioned that even though adversity is believed to be necessary to cause mental distress, adversity on its own is not sufficient to cause mental diseases. Other factors have been linked to the trigger of mental disorders, such as the context of the stress, the severity, the severity and the individual's resilience.

The participants also highlighted the fact that being stressed did not happen simply because they were immigrants. They mentioned that even if they were still living in their home country, the Democratic Republic of Congo, they would have been exposed to stressors.

That is why they claimed that being stressed was normal, they did not deny the fact that they were also stressed, but did not see the gravity of the stress enough to trigger a mental breakdown. Minimising the damages that could cause any stressful situation was a way for Congolese immigrants to enhance their self-esteem by enhancing their group performance (Burke, 2009).

An important point to note is that the assumption of high levels of trauma and stress within this vulnerable community are unfounded. Rich and complex survival strategies have emerged requiring refinement of our knowledge about migrant communities.

6.4 Help-seeking behaviours regarding mental health challenges (Objective4)

Three common options were identified among the participants. Those options include medical treatment, community support and prayers or a combination of the first two options.

Choosing the medical option was explained by the process of integration, where medical options have been made familiar to most immigrants in South Africa. However, since community support seems to occupy an importance place among the Congolese immigrants, when used without any other form of treatment, one can associate this chosen behaviour to separation, where immigrants keep their initial values without adopting the ones from their new environment, as explained by Schwartz et al, (2010).On the other hand, when there is a combination of both help community support, prayers and medical treatement,one can easily point out integration, since the immigrant, in this case, is keeping the values from his country of origin while adding help-seeking behaviours that are more used in the new environment.

6.5 Recommendations to improve management of mental health challenges in the Congolese community (Objective 5)

The participants mentioned the willingness to know more about mental health challenges: they claimed that the information shared during the discussions was based on what they knew. Education was the first recommendation from all the participants: not only will education

empower the Congolese community to improve the management of mental health challenges; the stigma associated to mental health challenges will also be reduced within the same community. Those in need of mental healthcare will then not be embarrassed to come forward and seek help.

This recommendation has wider significance for the region, according to Amuyungu-Nyamongo (2013). African communities are not particularly empathetic towards those affected by mental health challenges. Psychiatric services that isolate and tie patients down, and facing rejection and discrimination from community members are examples of what such a psycho-educational programme should address. Gender issues are also indicated as women face the real a possibility of not getting married through such stigmatisation.

Corrigan & Watson (2002) also highlighted the importance of education, suggesting that the media stop presenting mentally ill patients in a distorted and derogatory manner. Furthermore, communities were also advised not to believe what was being said about mentally ill people. Negative attitudes towards mentally ill patients, according to Corrigan et al (2012) were caused by the misconception, stigma and stereotypes.

Despite the fact that each community holds their own cultural beliefs, educating those communities on mental health challenges might not change their beliefs but will only help them find suitable methods to manage mental health challenges within their respective communities. The community in this study had different options for managing mental health challenges, such as the combination of medical treatment, community support and prayers.

Saxena et al (2007) have highlighted the fact that most developing countries have old mental health policies, which are as old as 30 years. That is why, this study can contribute to the development of a more responsive mental health policy for immigrant communities and their host countries. Some of the critical issues are planning for increased demands for access to mental health services as a consequence of improved understanding. Managing a process for diagnosing mental health stress levels that could impact negatively upon quality of life in the face of the proven resilience and capacity to survive are additional policy level interventions.

6.5 Revisiting the research question

Based on the results gathered during the focus group discussions, the understanding of mental health challenges was influenced by different positions on the acculturation process trajectory. This affirms the theoretical position to consider Social Identity Theory as only a partial explanatory framework. The issues under investigation have proved to be more fluid, complex and interrelated and furthermore do not fit neatly into the boxed process notions.

There were participants who did not change their cultural understanding and had the tendency to claim that mental health challenges in general and depression in particular was more prevalent in South Africa. Their attachment to their initial views, positioned their acculturation level as being based on separation, as defined by Ndika (2013). This refers to the process where immigrants reject values from their new environment while keeping theirs. Furthermore, that claim can also be linked to an assumption within Social Identity Theory, where the Congolese immigrants, by trying to enhance their performance, tended to undermine the community of South Africa.

On the other hand, there are also participants who changed their views regarding mental health challenges because they had loved ones who were affected and received treatment. Those participants were more understanding and believed that mental health challenges were normal medical conditions and did not necessarily prevent one from functioning. This category of the sample could be positioned within the assimilation notion of the acculturation trajectory.

Finally, there were participants whose views showed levels of integration, where they kept their initial beliefs and also adapted to the South African's coping strategies. Such examples include using prayers and community support while seeking medical intervention.

A research objective underpinning this study was formulated as follows: "How do Congolese immigrants understand mental health challenges and what are their preferred help-seeking behaviours? The focus group discussions provided rich narratives in answer to the question, and recommendations were given by the participants, in order to improve the management of mental health challenges in their community.

Chapter 7: Strengths, shortcomings of the study and recommendations for future research

This chapter will highlight the points that constituted the strengths of the present study, followed by the shortcomings. Finally, recommendations for future research will be provided and the dissertation is concluded with some reflective observations.

7.1 Strengths of the study

The facilitated conversations exposed the participants to new notions and the interaction allowed the participants to express their views regarding mental health challenges openly. The intervention served to challenge the "silences" around mental health challenges in the Congolese community in general and encouraged the participants to relate differently to people who might be experiencing mental health challenges.

As the participants came from different backgrounds; it allowed the researcher to understand views of the Congolese members from diverse backgrounds. There were participants who had tertiary education, while others did not. Furthermore, the participants had different professions, and the heterogeneity of the group resulted in rich discussions across the various groups.

Another positive aspect of the study, as stated by Etowa et al (2007), was that the present study was not conducted for the participants but with the participants. After answering questions from the semi-structured interviews during the focus group discussions, the participants played an active role in the research and contributed to solutions that will contribute to a deeper understanding and better management of mental health challenges for this specific, and other similar, communities.

Previous research has examined the understanding of mental health challenges in African communities in general and even in some Congolese communities. The present study explored Congolese immigrants in a specific country, South Africa. This contextualisation enabled a comparative analyses across two countries in a similar region, the DRC and South Africa.

The diversity of the group as well as the wide range in opinions was another strength of the study. First of all, the participants were from different age groups, and socio-economic backgrounds, and exposed differently to challenges of immigration. The sample consisted of students, housewives and those who were in the job market trying to earn a living. The diverse participants provided different views and enriched the findings. For instance, with men, the focus group sessions pointed out the tendency of male participants to underestimate the severity of mental health challenges, especially mood disorders.

7.2 Shortcomings of the study

The decision to focus on immigrants as a cluster without differentiating between categories such as political asylum seekers , and those relocating because of job opportunities, might have yielded different results, following Phelan et al (2000) and Jacob (2013). Furthermore, the participants from the present study were all able to rely on their community and had either friends or family members who could serve as a support system when they were experiencing challenges related to immigration. There could be Congolese immigrants with no support and facing challenges such as living illegally in South Africa and living in camps prior to repatriation such as in Lindela. Including Congolese immigrants facing different realities could have generated deeper and more nuanced information.

The convenient location, Gauteng, is a deterrent to having a full profile and more comprehensive understanding of the lived realities of the sample within the entire country.

There are noteworthy aspects with regard to the notion of the age variable as used during this study. No significant differences were reported from the various age groups. In addition, the duration of immigration does not appear to be a significant variable in the acculturation process either, as no distinctions were found across the groups based on the years of immigration to South Africa. It might be that a decade, given that the average number of years since immigration is10.37 years, is too short a period to really examine lived experiences in stages.

At some point, during the focus group discussions, the participants had the tendency to repeat responses and ideas. Some participants barely knew anything about mental health challenges. So the researcher had to continually probe if their answers were actually about mental health challenges or what they thought were mental health challenges.

When mentioning mental health challenges as a disease, there was a concern that the participants were judging and victimising mental health patients, since their answers were based very much on a biomedical model. While the researcher was probing their responses the participants were not asked to change their answers in order to please the researcher, but they were asked to elaborate more.

Furthermore, some of the participants were giving answers that would sound socially desirable, in order to please the researcher. This weakness has been pointed out by Terreblanche et al (2006). Once the researcher noticed that participants were giving answers that seemed more general, the participants were asked to elaborate upon their answers.

7.3 Recommendations for future research

The present research provides a cornerstone to the cultural understanding and help-seeking behaviours of Congolese immigrants living in a specific geographical location in South Africa.

While the present study focused on the effect of acculturation to see whether there was a change in the understanding on mental health challenges, one could conduct a cross-generational study to investigate the differences of cultural understanding and help-seeking behaviours between immigrants and their children.

Another potential area for investigation could be a longitudinal study that measures change in the understanding of mental health challenges of immigrants. A quantitative and longitudinal approach, focussing on larger samples and trends, is more likely to have a greater impact on policy and possible resource allocation changes.

The understanding of mental health challenges remains a key issue not only for the present study but even at a broader scale, such as in the development of policies. For instance, even though in some instances the difference in understanding was highlighted by the difference in terminology or the lack of direct translation, policies have not been responsive to such

realities. Mental health patients are often dealt with insensitively from a similar "containment and medication" approach without addressing their particular needs. Different cultures experience mental health patients as being dangerous and violent or totally with unable to cope in the real world. Having a differentiated service would lead to addressing the individual needs of mental health patients more effectively, and could prevent tragedies such as the one which recently affected around one hundred (100) psychiatric patients in South Africa.

The Congolese immigrants who took part in the present study constantly mentioned that they were able to cope with mental health problems "automatically". The reported alternative coping mechanisms could be further explored, and shared with other vulnerable immigrant communities in other contexts. Finally, it would be very interesting to know more about the ways in which communities deal with depression without using any western approaches to treatment. Comparing immigrants from two or three different communities, and analysing their alternative ways of coping with mental health challenges would contribute to such a body of knowledge, building upon the work of Kopinak (2015)..

While the findings from the current study showed that the participants were affected by acculturation at different levels, psycho-education remains important in order to circulate facts and scientific information on mental health challenges rather than relying on the stereotypes and rumours that people are often exposed to. This will also counter stigmatisation and the reluctance to make use of available services.

Given the better understanding of the needs and lived realities of Congolese immigrants regarding mental health challenges during relocation provided by the present study, additional research should be conducted on effecting improvements to mental health policy and practices, in both developing and other countries, where immigrants and refugees are found. Managing migrant populations during a global period characterised by massive dislocations of citizens remains an important area for policy development and adequate resourcing. For example, recent public reviews in the grey literature have claimed that it costs South Africa R800 million annually to provide for 6440 incarcerated foreigners, leading to proposals for rethinking existing bilateral and multilateral agreements. Such an initiative should also be introduced into departments of foreign affairs, or their equivalents in SADC, to consider a more humane and sustainable approach to the migration and resettlement of communities.

7.4 Conclusion

Coming from a country undergoing armed conflicts and facing all the negative consequences caused by the ongoing war, one can easily assume that all Congolese citizens would face a number of mental health challenges and burdens. With immigration being one of the consequences of escaping from turbulent societies and the accompanying socioeconomic and other problems, Congolese immigrants are likely to have to face additional stressors linked to decisions to leave their country of birth. However, mental health burdens, are very much linked to beliefs and is known to be stigmatised.

The present study has, once again confirmed claims made by Rathod et al (2017), who mentioned that mental health challenges need to be understood contextually. The present study further confirms that help-seeking behaviours are specific to communities, and depend not only on resources available and knowing how to access services, but also on beliefs regarding mental health challenges. Adding to beliefs, stigma remains one of the greatest challenges faced by those affected by mental health challenges, as mentioned by Mantovani et al (2016). Psycho-education has been suggested by participants from the present study as a way to address this problem.

The present study allowed a subjective understanding of mental health challenges in this specific community, exposed to stressors due to the ongoing political and socioeconomic challenges in their home country, and the additional stressors linked to immigration. More is known about the way this sample of Congolese immigrants understand mental health challenges, and how they seek help when confronted by mental health challenges. The study has added value to the research outcomes through providing recommendations by the participants for their own community.

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Appendix A: Informed consent form

Title of the research**: Exploring the understanding and help-seeking behaviours of Congolese immigrants in South Africa regarding mental health challenges.**

Student's name: **Justine Rachel Ilondo**

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Dear Participant,

Thank you for being willing to take part in the present study. You are welcome to withdraw from the study at any stage without being questioned or forced to stay. Furthermore, withdrawing from the study will not penalise you in any case.

Questions will be asked in focus groups. You are more than welcome to ask for any clarification regarding the topic.

Participants are not forced to give their real names. The names of the participants will not be published anywhere, and the results will only be published as a whole, not as per individual participant's answers.

The results will be used as part of my dissertation towards my Masters in Psychology at the University of South Africa.

The results of the research will be made available to participants who would like to see them.

Should you have any questions related to the research, feel free to contact me.

This is to confirm that I (name) ----------

Consent to participate in the study. I understand that I can withdraw from the study at any time and that providing my name is not compulsory.

Signature of participant: ----------

Signature of researcher: ----------

Date: ----------

Thank you for participating in this study.

Questions asked during the focus group sessions

- How have you coped with stressors related to immigration?
- What do you understand by mental health challenges?
- How has living in South Africa culture changed your understanding of mental health challenges?
- Tell us about people who are affected by mental health challenges in your community?
- What do you think about those affected by mental health challenges?
- What kind of help do they seek and from whom?
- How could the situation regarding the management of mental health challenges be improved?