CONCEPTUALISATION OF MENTAL ILLNESS BY VHAVENDA INDIGENOUS HEALERS

By

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Declaration

I declare that **THE CONCEPTUALISATION OF MENTAL ILLNESS BY VHAVENDA INDIGENOUS HEALERS** (Mini- dissertation) submitted at the University of Limpopo for Masters of Arts in Psychology has not been previously been submitted by me for a degree at this or any other university; that is it is my work in design and in execution, and the material contained herein has been dully acknowledged.

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Salome Thilivhali Sigida   Date

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Student number

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Abstract

Several studies have shown that alternative health care practitioners play an important role in addressing the mental health care needs of individuals by offering culturally appropriate treatment. In South Africa, it has been suggested that indigenous healers are frequently consulted for mental illness when compared to their Western trained counterparts. The aim of the present study was to explore the conceptualization of mental illness by VhaVenda indigenous healers. Specifically, the study sought to achieve the following objectives: a). Establish what VhaVenda indigenous healers understand about mental illness; b). Determine the types of mental illness identified by VhaVenda indigenous healers; and, c). To determine what indigenous healers in this community perceive as the signs and symptoms of mental illness.

A qualitative approach, and in particular, the case study method was used in the present study. Ten indigenous healers (male = 8: female = 2), aged between 35 and 60 were selected through snowball sampling and requested to participate in the study. Data were collected using semi-structured interviews and analysed using the content analysis method. The following psychological themes emerged from the study: a). participants understanding of mental illness; b). causes of mental illness; c). types of mental illness; d). signs and symptoms of mental illness; e). diagnoses of mental illness and f). Treatment of mental illness. The findings revealed that there are multiple causalities of mental illness and were accounted for by African indigenous beliefs. The findings of the present study further suggested that the participants do not have an elaborate nosological system that distinguishes between the different types of mental illness. Instead of giving names to the illnesses, the participants tended to describe the illness based on what is perceived as the cause which emanate from cultural ideologies. Furthermore, the results revealed that indigenous healers use the following treatment modalities to treat mental illness: namely, the use of herbs and indigenous practices. The study is concluded by making a few recommendations, that among others include consideration been given to some form of collaboration between indigenous healers and western trained health care practitioners.

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List of Abbreviations and Acronyms

APA: American psychiatric Association

DSM: Diagnostic and Statistical Manual of mental health

HSRC: Human Sciences Research Council

IDP: Integrated Development Planning

SADAG: South African Depression and Anxiety Group

WHO: World Health Organization

CHAPTER 1: BACKGROUND AND ORIENTATION

1.1 Introduction

Throughout the world there is an increasing awareness of mental illness as a significant cause of morbidity (Kabir, Iliyasu, Abubaka & Aligu, 2004). The World Health Organisation estimates that mental health and neurological disorders are the leading causes of ill-health and disability, but there is an appealing lack of interest from government and NGOs. One reason behind this apparent indifference is the market-driven nature of aid. At NGO level, allocation of funds is strongly correlated with a project's marketability to the general public. Aid spending remains focused on the big three communicable diseases of HIV/AIDS, Malaria and TB, with many other health conditions, including mental illness receiving only a fraction of the available funding (Chambers, 2010).

The psychiatrist-to patient ratio in Africa is less than 1 to 100,000 and it's reported that 70% of African countries allocate less than 1% of the total health budget to mental health (Dovi, 2013). A 2008 report compiled by the World Health Organisation states that there are only 0.06 mental health professionals per 100,000 people in Liberia and the S.Grant Mental Health Hospital is the sole inpatient facility for those suffering from mental illness. A study conducted by the American Medical Association found that 44% of the Liberians adults exhibit symptoms of Post-Traumatic Stress Disorder (PTSD). The likelihood of these people receiving treatment is very low, when taking into account the scarcity of mental health facilities in that country (Dovi, 2013).

In South Africa, one third of the population is reported to have some form of mental illness at some point in their lives, with only 75% of them getting any kind of help (Tromp, Dolley, Laganparsad & Goveneder, 2014). More than 17 million people in South Africa are dealing with depression, substance abuse, anxiety, bipolar disorder and schizophrenic illnesses that round out the top five mental health diagnoses (Tromp et al., 2014). Family members are often the primary care givers of people with mental illness. There is an enormous gap between the need for treatment of mental illness and

the resources available. In developed countries with well-organised healthcare systems, between 44% and 70% of the patients with mental illness receive treatment. In developing countries the figures are even startling, with the treatment gap being close to 90% (World Health Organization, 2003).

Mental illness and the associated psychosocial disabilities are sources of considerable morbidity and impose a significant drain on national resources (Lopez, Mathers, Ezzati, Jamiso & Murray, 2006). The majority of the world's 450 million people who suffer from mental illness live in developing countries, and less than 10% have access to mental health care (World Health Organization, 2001). Several studies have shown that alternative practitioners play an important role in addressing the mental health care needs of individuals and communities by offering culturally appropriate treatment (Nattrass, 2005; Freeman, Lee & Vivian 1994; Mbanga, Niehaus, & Mzamo, 2002). In many traditional African belief systems, mental illness is perceived to be caused mainly by ancestral wrath or witchcraft. Within many African cultures, psychotic behaviours often prompt supernatural explanations (Nyika, 2007). According to Kabir, Iliyasu, Abubakar and Aliyu (2004), the recognition of mental illness depends on the careful evaluation of norms, beliefs and customs within the individual's cultural environment. Thus, people's beliefs and attitudes regarding mental illness can only be studied within a cultural context.

Most South Africans have limited access to psychiatric care and psychosocial care. According to Statistics South Africa (2012), South Africa has a population of approximately 51, 8 million people. Thwala and Edwards (2010) observed that currently, there are about 6,000 psychologists, 10,000 social workers, 30, 000 medical doctors and 125,000 nurses to care for nearly 50 million people in South Africa. Effectively, this means that other community helping resources like indigenous healers and African faith healers do most of the work in the treatment of mental illness (Thwala & Edwards, 2010). Indigenous healers and religious advisors are viewed as having expertise in helping to ameliorate mental illness. Furthermore, these alternative health care providers are often more accessible than Western forms of mental health providers (Karim, Zigubu-Page & Arende, 2004). According to Peltzer, Mnqundaniso and Petros

(2006), indigenous healers are widely dispersed throughout South Africa, and are more knowledgeable about the cultural norms in the communities where they operate. Consequently, theid advice and interventions are often sought and acted upon by their clients.

1.2 Research problem

Several studies have confirmed that indigenous healers are frequently consulted in South Africa for mental illness when compared to their western trained counterparts. One of the central reasons that indigenous healers are consulted is that they offer treatments that are congruent within the culture of the patients seeking treatment (Freeman et al., 1994; Mbanga et al., 2002; Nattrass, 2005; Patel, Simunya, & Gwanzura, 1997). They tend to be the entry point for care in many African communities and even more so for those complex diseases that most frequently jolt family dynamics and shake community stability. They frequently have high credibility and deep respect among the communities they serve (Richter, 2003).

Existing evidence demonstrates a connection between culture and diagnosis, symptoms, course and treatment of mental illness (Eshun & Gurung, 2009). Nkungwana (2005) indicates that the vast majority of the population of sub-Saharan Africa is reported to obtain their health care from indigenous healers. Most people in the rural communities prefer to go to indigenous healers to seek treatment because they believe they are knowledgeable and can restore their well-being (Nkungwana, 2005). Whilst there is evidence to suggest that most people in rural communities prefer indigenous healers, there appears to be very little research that has been done to understand the role of indigenous healers in the promotion of mental health in rural communities. Based on the relatively fewer studies that have been conducted on this particular subject, the current study seeks to understand the conceptualisation of mental illness by indigenous healers in a rural community in South Africa.

1.3 Operational definitions of concepts

- **Indigenous healers**: This refers to individuals who have undergone some apprenticeship and have "graduated" as an indigenous healer (Bührmann, 1979). In the context of the present study, the concept indigenous healer will be used interchangeably with the concept traditional healer.

- **Mental illness:** This is described in the Diagnostic and Statistical Manual (DSM-5) as a clinically significant behavioural or psychological syndrome or pattern that occurs in an individual's cognition, emotion regulation, or behaviour that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning (DSM 5, 2013). In the context of the present study, mental illness will be understood in the same way that is reflected in the DSM 5.

1.4 Purpose of the study

1.4.1 Aim of the study

The aim of the study is to explore the conceptualisation of mental illness by VhaVenda indigenous healers.

1.4.2 Objectives of the study

Specifically, the objectives of the study were:
- To establish what VhaVenda indigenous healers understand about mental illness;
- To determine the types of mental illness identified by VhaVenda indigenous healers;
- To determine what indigenous healers perceive as the signs and symptoms of mental illness.

1.5 Outline of the chapters

Chapter one provides the background to the study including an outline of the research problem. The aim and objectives of the study were also presented. In chapter two relevant literature pertaining to the subject under investigation is reviewed. The

theoretical framework that guided the researcher is also discussed. In chapter three the methodology that was followed is outlined. In this regard, issues like the research design, sampling, data collection and analysis are addressed. The quality criteria that guided the investigation, including the ethical issues that were onserved in conducting the study are highlighted. Chapter four presents the findings of the study. In chapter five the findings of the study are discussed in the context of existing literature and provide the discussion of the findings. Chapter six provides conclusion, limitations and recommendations for future research.

CHAPTER 2: LITERATURE REVIEW

2.1 Introduction

This chapter discusses the prevalence of mental illness, and the different views of mental illness from relevant literature. The theoretical framework for the present study which is the Afrocentric theoretical framework will also be highlighted.

2.2 Prevalence studies on mental illness

The burden of mental illness is felt not only through the primary presentation of mental illness, but also through its high co-morbidity with other illnesses (Prince et al., 2007). In the South African context, the relationship between HIV/AIDS and mental illness is particularly pertinent. Research in South Africa shows that with high prevalence of mental illness, HIV coexists in a complex situation (Ciesla & Roberts, 2001). Mental illnesses common to HIV diseases cause morbidity and are often not detected by physicians (Department of Health, 2013).

A World Health Organisation (WHO) funded study, the Global Burden of Disease Study (GBD), investigated the mortality and disability associated with different illnesses (Chebbet, 2012). In that study they found that neuropsychiatric conditions were found to contribute 10.5% of the world burden of disease in 1990. This increased to 12% in 2000 and is projected to reach 15% by 2020. Depression is ranked the fourth leading cause of global disease burden in 1990 and is expected to be second in schaemic heart disease by the year 2020 (Chebbet,2012).

In societies such as South Africa, where there is a history of exposure to violence many individuals are vulnerable to developing post-traumatic stress. PTSD may be triggered by life threatening events such as violent personal assaults, natural or unnatural disasters and accidents. Although not all individuals exposed to life-threatening events will develop PTSD (Ahmed, 2007; Sher, 2004), some may develop other trauma-induced common mental illness such as anxiety and depression (Ahmed, 2007; Carey, Stein, Zungu- Dirwayi & Seedat, 2003; Zungu- Dirwayi, Kaminer, Mbanga & Stein,

2004). Common mental disorders account for high burden of disease and disability in low and middle income countries (Lopez et al., 2006; WHO, 2001). These disorders are also responsible for up to 10% of the global disease burden (Kessler et al., 2009).

Mental illnesses have serious economic and social costs. These include direct costs related to the provision of health care, and indirect costs such as reduced productivity at home and work, loss of income and loss of employment. The relationship between poverty and mental illness has been described as a "vicious cycle", people living in poverty are at increased risk of developing mental illness through the stress of living in poverty, increased obstetric risks, lack of social support, and increased exposure to violence and worse physical health (Department of Health, 2013).

Several factors suggest that the South African population may be at especially high risk of mental illness. Prior to 1992, the racialised social policies of Apartheid and the political violence and victimisation that grew out of the anti-apartheid struggle created a context conducive to increased risks of mental illness (Dawes, 1990). Other characteristics of the South African population that might be associated with an especially high prevalence of mental illness include the harsh economic circumstances and the high risk of HIV/AIDS (Seedat & Stein, 2007). This advance towards the acknowledgement of mental health concerns in Africa led to further understanding that untreated mental illnesses could lead to considerable individual costs for Africans. Its impact is experienced directly through financial costs and indirectly through the loss of employment and reduced productivity (Hugo, Boshoff, Traut, Zungu-Dirway & Stein, 2003).

In South Africa all health services and budgets are decentralised to the 9 provinces. There is a wide variation between the provinces in the budget and the resources available for mental health care. Mental health services are organised in terms of catchment areas in all provinces. In South Africa in 2007, there were 3,460 outpatients mental health care facilities; 80 day treatment facilities; 41 psychiatric inpatients units located in general hospitals with a total of 2.8 beds per 100,000 populations; 63 community residents facilities with a total of 3.6 beds per 100,000 populations and 23

mental hospitals providing a total of 18 beds per 100,000 population 9 provincial range 8-39 (World Health Organization, 2007). These figures may have changed since 2007. It can be safely concluded that the state of the country's mental wellbeing is in severe crisis. South African Depression and Anxiety Group (SADAG) claims that less than 16% of patients receive treatment for mental illness (South African College of Applied Psychology, 2013).

There are several factors which limit the needed progress such as lack of trained professionals and lack of communication between primary and district care. In addition, the cultural context of South Africa increases the complexity of the situation (Petersen & Lund, 2011). For example, the World Health Organization (2003) reports that one in four people worldwide will be affected by mental illness at some point in their lives and 10% of world's population suffer from depression. In a study conducted in 2009, it was found that of the 16.5% of people suffering from mental illness only 25% had received treatment (Petersen & Lund, 2011). In an earlier study conducted by the World Health Organization, it was found that approximately 56% of mental health care still take place in institutionalised settings (World Health Organization, 2007).

World-wide report from the World Bank indicates that mental disorders and especially depression are amongst the most prevalent health problems, resulting in enormous loses in terms of human resources and economic potential. An epidemiological study conducted by Bhagwanjee, Parekh, Paruk, Petersen, and Subedar (1998) amongst adults in Kwa-Zulu Natal, revealed an unexpectedly higher prevalence of anxiety disorder amongst adults. According to Tomlinson, Grimsrud, Stein, Williams and Myer (2009), 17 million South Africans claimed to be suffering from mental illness, 16.5% of adults South Africans suffered from common mental disorders over 12 months study period and 30.3% of adults South Africans will have suffered mental disorders in their lifetime. Most prevalent class of life time disorder was anxiety disorder (15.8%), followed by substance abuse disorder (13.3%) and mood disorder (9.8%). The most prevalent individual lifetime disorders were alcohol abuse (11.4%), and agoraphobia without panic (9.8%) (Tomlinson et al., 2009).

2.3 Western perspectives on mental illness

Mental health is an integral part of general health which the World Health Organisation views as not just merely the absence of the disease or ill-health but the complete state of physical, mental and social well-being (World Health Organisation, 1997). The term mental illness refers to all diagnosable mental disorders which are health conditions characterised by abnormalities in mental functioning. Mental illness is displayed in varying degrees of intensity and duration and it is possible for many signs of mental illness to be present without meeting the full criteria of a mental illness. The most severe of these illnesses are triggered by a malformation of the brain or a malfunctioning of its complex electrochemical process resulting in distorted thinking, feeling and behaviour (Kaplan & Sadock, 1997).

Explicit within the definition of mental illness provided in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorder (DSM 5) (American Psychiatric Association, 2013) is that the condition must currently be considered a manifestation of behavioural, psychological, or biological dysfunction in the individual. Scientist such as psychiatrists and psychologist may draw from a number of assumptions as the causes of mental illness such as genetic predisposition, neural dysfunction, disturbed parent child relationship or biochemical factors (Kaap, 1991). Mental illness largely involves disorders in psychological or behavioural functioning. Over the years, many western theories have been developed to explain mental illness (Sue, Sue, & Sue, 2003). A few of these major theories are briefly described below.

The psychodynamic theories assume that mental illness is a result of unconscious psychological conflicts originating in childhood. Sigmund Freud, the founder of this theoretical perspective, believes that both normal and abnormal functioning is motivated by irrational drives (which are sexual in nature) and determined by childhood experiences (Freud, 1940). He further suggests that mental illness is caused by the imbalance in the structure of personality (namely, the id, ego and the superego).

The imbalance in the structure that results in the mental illness is created when the ego is too weak to manage conflict between the id and the superego more effectively (Meyer, Moore, & Viljoen, 2003). According to Stern (1985), when the id impulse threatens to break through in consciousness, it results in anxiety. For Freud these conflicts have historical causes, for example, when a parent is over protective of the child, the child can develop a weak ego due to over protection and will have ineffective defence mechanism. Similarly if a parent is too strict, an overly strict Super-ego will develop which will create a moralistic anxiety when it conflicts with the Ego. When the Ego fails to cope with anxiety coming from the conflicts between the Id and the Super-ego using defence mechanism the result is mental illness. This approach uses free association, dream analysis, analysing resistance, analysing transference and interpretations as major techniques to help the unconscious become conscious (Huffman, 2007).

Behavioural theorists, like BF Skinner, including the social cognitive learning perspective does not attribute mental illness to internal conflicts or guilt feeling like Freud. Skinner attributes mental illness as lack of effective behaviour or behaviour that does not help the individual in coping with the environment (Corey, 2005). Mental illness is seen as the product of unfortunate early learning or conditioning in the three processes namely; classical conditioning, operant/ instrumental conditioning and vicarious learning process. The social cognitive learning perspective contends that mental illness is a result of learning. For example this perspective attribute that people learn unhealthy behaviours like smoking, drinking alcohol, robberies, etc. from observing the model. According to Bandura, a social cognitive theorist explains the lack of self-efficacy to attribute in the development of abnormal behaviour (Meyer et al., 2003).

Erik Erikson, a psychoanalyst, focused on the boundary between the child and environment and the graphed evolution of the maturing ego's relations with an expanding social world. He identified dilemmas or polarities in the ego's relations with the family and larger social institutions at nodal points in childhood, adolescents, and early and middle adulthood. His epigenetic principle holds that development occurs in

sequential, clearly defined stages and that each stage must be satisfactorily resolved for the development to proceed smoothly. He pointed out that if successful resolution of a particular stage does not occur; all subsequent stages reflect that failure in the form of physical, cognitive, social or emotional maladjustment (Kaplan & Sadocks, 1997).

Erikson's eight stages of the life cycle are; trust versus mistrust, autonomy versus shame and doubt, initiative versus guilt, identity versus role confusion, industry versus inferiority, intimacy versus isolation, generatively versus stagnation, and integrity versus despair. Each stage of the life cycle has its own psychopathological out-come if it is not mastered successfully. For example an impairment of basic trust leads to basic mistrust. This lack of trust may be manifested by dysthymic disorder. Basic mistrust is a major contributor to the development of schizoid personality disorder and, in most severe cases to the development of schizophrenia (Kaplan & Sadocks, 1997)

Within the ecosystemic perspective, mental illness is present in a system that reveals lack of balance and/or complexity (Meyer et al., 2003). For example, in a family where there is abuse (sexual or physical), the family tends to be closed from a wider community or other extended family members. According to Becvar and Becvar (2000), closed systems are unable to interact with external environment, and they become isolated and resist necessary changes. They have ineffective responses to demands for change, becoming disorganised and disordered.

Within the behavioural and social cognitive approaches, the primary objective is to improve the client's functioning in the particular situation they find problematic. This approach specifies treatment goals in concrete and objective terms, focuses on the client's current problems, the factors influencing them and emphasis observing overt behaviour. According Corey (2005), the counsellor is highly active in this approach to act as a trainer, providing an educational role, helping the clients to learn new skills and transferring these skills to real life situations.

According to Corey (2005), the goal for counselling in the Social Cognitive Learning approach is to teach the client how to dispute and challenge irrational beliefs and substitute them with more rational statements, which results in a change that gives rise to new set of behaviour and feelings. The humanistic-existential theory relies heavily on the assumption that people all have the potential for growth and change. This theory maximises that personal growth and mental illness is believed to be caused by a blockage or disruption of the normal growth potential and this leads to a defective self-concept (Huffman, 2007).

According to Huffman (2007), Psychological theories have been widely criticised because they are individualistic in nature and these theories tend to emphasise independence, the self and control over one`s life while most African cultures are collective in nature and emphasise interdependence upon one another.

2.4 African perspectives on mental illness

In many parts of Africa, mental illness is understood to be present when an individual shows behavioural signs and symptoms that are perceived to deviate from social norms (Koen, Niehaus, Muller, & Laurent, 2003; Mufamadi, 2001; Mzimkulu & Simbayi, 2006; Robertson, 2006). For example, a study by Mufamadi (2001), found that a number of symptoms were associated with mental illness, including; aggression, talking incoherently, isolation, shouting loudly, confusion and strange behaviour and reported perceived causes such as heredity, witchcraft, sorcery, disregard of cultural norms and spirit possession.

The Dagon people of Malawi, recognise someone to be mentally ill when he/she talks loudly even when speaking to elders; is always alone; and refuses to be with others of his/her own age group (Benduce, 1996). According to Chavunduka (1978), in Zimbabwe a person is considered mentally ill if he/she performs foolish acts without realising what he or she is doing. Mental illness can therefore be explained in mystical terms by indigenous healers to fit the belief systems of their clientele, as ancestral spirits are not a relic of the past, but archetypes of the collective unconscious individuals (Bodibe,

1992; Mabetoa, 1992; Mabunda, 2001). Musara, Maramba, and Fuyane, (1995) and Mutebirwa (1989) in Zimbabwe found that psychosis was believed to be caused by supernatural powers. Similarly, in a study conducted in Malaysia by Razali, Khan, and Hasanah (1996) found that 70% of Malaysian indigenous healers attributed mental illness to supernatural causes such as witchcraft and angered ancestors.

According to Aina (2008); Srinivasan and Thara (2001); and Kadri, Manondi, Berrada and Moussaoni (2004), the vast majority of people in developing countries attributes mental illness to stressful life events, supernatural phenomena, and heredity. According to Vontress (2001), indigenous knowledge systems regarding healthcare, or indigenous healthcare approaches and methods have been in existence since time immemorial. They have been playing significant roles in improving human conditions, or elevating the quality of life, promoting health, curing disease, preventing illness, facilitating personal empowerment and social transformation.

African history is a widespread custom that ancestors choose someone within the family, which depends on the powers that the previous ancestors had (Kale, 1995). Mufamadi and Sodi (1999) noted that many traditionally-orientated Africans who are called to be indigenous healers are believed to be chosen by supernatural agents like deities, ancestors and the Supreme Being. These "chosen" people to become indigenous healers may display signs like aggression, social withdrawal, or bizarre behaviours before they accept the calling and undergo training (Mufamadi & Sodi, 1999). These people become mediators between the ancestors and the community also takes up the position as a leader in the community. Indigenous healers believe that if one fails to adhere to the calling the person is doomed with bad luck and also with illness that is incurable (Kale, 1995). Zanemvula (2008) also illustrated that if the "chosen" person continues to decline the calling they will continue to be sick for some time until they finally accept. The most mystical point about the resistance of the calling is that they will have chronic illness that western medicine is unable to diagnose.

Furthermore, Hopa, Simbayi and Du Toit (1998) stated that the training of diviners begins with a "calling" or a state of apprehension that takes the form of a dream involving the appearance of an ancestor who informs the individual of the wishes of the ancestral "shades" or spirits to use the individual for healing people. By accepting the call and moving from a neophyte or novice via an apprenticeship to a seasoned diviner for a period of time, the individual learns to get in the spirit world. The individual concerned then becomes blessed with clairvoyant powers to divine and act as a mediator between the living and the dead. This process can take several years to be completed. The powers are revealed in dreams and during diviner's rituals such as ritual dance. The training of diviners involves, amongst other things, assessment of illness, ability to locate lost objects, and treatment of diseases. In addition sometimes herbs are revealed to the individual by their ancestors.

Cultural and religious teachings often influence beliefs about the origins of mental illness and shape attitudes towards the mentally ill. In addition to influencing whether the mentally ill experience social stigma, beliefs about mental illness affect patient's readiness and willingness to seek and adhere to treatment care (Nieuwsma, Pepper, Maack, & Biergenheir, 2011). A review of ethnocultural beliefs and mental illness by Abdullah and Brown (2011) highlights the wide range of cultural beliefs surrounding mental health. For instance, while some American Indian tribes do not stigmatize mental illness, others stigmatize mental illness. However, the stigmatization of mental illness can be influenced by other factors such as perceived cause of mental illness. Furnham (1997) also notes that cultural attitude towards illness particularly affects the availability of professional help. The issue of acceptability of professional help is therefore particularly important. For example, if a cure is recommended for a patient who does not believe in the western theories pertaining to the cause and cure of a mental illness, the patient suffering from such illness may not follow the guidelines for the cure. It is therefore important for the causal explanations and treatment of a particular mental illness to be meaningful to a patient in terms of his/her cultural context and realities. Mzimkulu and Simbayi (2006) pointed out that many traditional Africans believe that mental illness originates as a punishment from the gods for evil.

According to Beuster (1997), in traditional African communities abnormal behaviours like alcoholism, drug-abuse and addictions, constant and unresolved conflicts in relationships are attributed as external forces that cause mental illness. Buhrmann (1984) and Ngubane (1977) mention poisoning as one of the popular etiological factor advanced to explain some physical and psychological complaints presented by African patients.

According to WHO (2002), traditional healing or medicine is the sum total of knowledge skills, and practices based on theories, beliefs, and experiences indigenous to different cultures that are used to maintain health, as well as to prevent, diagnose, improve, or treat physical or mental illness. According to Uys (1989), the African treatment and healing systems differs from the western approach in two ways. First, it focuses on "who" and not what caused the disease. The question is mainly whether it was witch craft or angered ancestors. Second, treatment is concerned with the total person and often includes close and distant relationships. Such treatment often includes dancing, singing in the patient's home while evocating evil spirits. This culminates with a feast involving the sacrifice of an animal to appease the spirits and the drinking of traditional liquor.

Western psychological practices rely heavily on natural science whilst ignoring the social conditions, shaping people's conceptualisation of illness, health, healthcare and associated health seeking behaviours (Angelique & Kyle, 2001; Vijver, & Leung, 2000). For example depression is regarded as a consequence of some malfunction within an individual's bodily or psychical structures, when considered from a western perspective. On the other hand, the conceptualisation of depression (including the associated help-seeking behaviours) in many sub-Saharan Africa communities take into account the spiritual, social and cultural factors (Sodi, 2009; Swartz, 1997). According to Mdleleni (1990); Mzimkulu and Sibaya (2000); and Ngubane (1980), "*amafufunyane*" which is described as an extreme form of depression with psychotic features (including hysteria and suicidal tendencies) is explained in terms of spirit possession.

2.5 The role of indigenous healers in Moagi (2009) defines an indigenous healer in a South African context as someone who possesses the gifts of receiving spiritual guidance from the ancestral world. Moagi further contends that indigenous healers play an important role in assisting people who present with either mental or physical health problems in South Africa. Skuse (2007) argues that indigenous healers are a significant source of mental health support in many parts of the world, including Africa. Indigenous healers offer parallel systems of belief to conventional medicine regarding the origins and treatment of mental health problems (Skuse, 2007). The important role played by indigenous healers in the provision of mental health service in South Africa is highlighted by the fact that a substantial proportion of people seen by indigenous healers suffer from mental health problems.

Peltzer et al., 2006 found that mental health problems were 14th on the list of the most common conditions seen by indigenous healers. In South Africa, under the apartheid government African indigenous healers were prohibited from practising and as a health practitioner. A number of centres have assessed the role of indigenous healers in mental health intervention. A common finding was that indigenous healers could recognise symptoms of severe illness but that they expressed strong belief in supernatural factors as ultimate causes of mental illness and this influenced the treatment they gave (Abbo, 2011). In the South African Traditional Healers act No. 35 of 2004, indigenous medicine is defined as "an object or substance used by indigenous health practitioners for the diagnosis, treatment or prevention of a physical or mental illness; or any curative or therapeutic purpose including the maintenance or restoration of physical or mental health or well-being in human beings, but does not include a dependence-producing or dangerous substance or drug".

Richter (2003) recognises that the World Health organisation (WHO) finds it a challenge to give one clear-cut definition to the broad range of characteristics and elements involved in the concept of indigenous medicine. However, for the sake of convenience they state that "it includes diverse health practices, approaches ,knowledge and beliefs incorporating plant, animals and/or mineral based medicine, spiritual therapies, manual

techniques and exercise applied singularly or in combination to maintain well-being, as well as to treat, diagnose or prevent illness" (Richter, 2003).

One of the definitions given for African Indigenous Medicine by the World Health Organisation is that:

> "it is the sum total of all knowledge and practices, whether explicable or not, used in diagnosis, prevention and elimination of physical, mental, or societal imbalance, and relying exclusively on practical experiences and observation handed down from generation to generation, whether verbally or writing" (Richter, 2003, p.7).

According to Chan (2008), indigenous healthcare is generally commonly used in most parts of Africa, Asia, and Latin America, and for millions of people living in the rural areas of these parts of the world indigenous medicine, indigenous treatment and indigenous healers are the main, if not the only source of healthcare. Research indicates that indigenous healers provide primary health care to approximately 80% of the population of South Africa (Mkhize & Uys, 2004). Semenya, Potgieter and Erasmus (2012) have pointed out that indigenous healers diagnose and treat diseases according to the symptomatic presentation by their clients as they do not have access to laboratory results to guide the diagnosis and treatment of the diseases. The therapeutic interventions made by the indigenous healers are directed, not only at the patient, but also their family and environment (Dlamini, 2006). According to Kale (1995) indigenous healing aims to include all aspects of psychological healing and go to the root of the sickness or the cause by consulting with the bones to show the client what has gone wrong and what the cause of the illness is. There is a strong cultural component in the treatment techniques of indigenous healers (Dlamini, 2006). Kleinman and Sung (1979) reported that 10 out of 12 cases treated by indigenous healers rated themselves as cured. According to these researchers, similar belief system about health and illness and healer's holistic approach explained the subjective improvement.

Saraceno et al., (2007) suggest that in low to middle income countries, "none professional", which would include indigenous healers, offer a potentially important human resource for the provision of mental health care. The indigenous healing process follows three different steps which the identification of the cause or the discovery of violation of the established order through supernatural divination, the removal of the hostile source by neutralisation of the sorcerer or seeking of the ancestor's forgiveness with sacrifice and rituals to appease their anger or by prescription of certain medication (Truter, 2007). Hadebe (1986) found that some indigenous healers intervention strategies at a physical level include the use of namesis, anema, steaming, taking medicine nasally and vaccination. According to Buhrmann (1984), and Ngubane (1977), divination bones are also reported to be used in other parts of Africa to diagnose illnesses.

Skuse (2007) identified three categories of indigenous healers, namely: a). diviners, most of whom are female and chosen by their ancestors to this calling; b). herbalists; and, c). faith or spiritual healers. Medication is the most common therapeutic method used by indigenous healers. Other methods would include psychosocial counselling, simple surgical procedures, rituals and symbolism (Karim et al., 2004). Karim et al. (2004) went further to say that the medications used by indigenous healers can be classified into three categories, namely: preventative and prophylactic medication, treatments for ailments and lastly, medications used to destroy the power in others. Indigenous healers provide culturally appropriate care which is linked to indigenous explanatory models of illness held by many South Africans.

Melato (2000) explores traditional healer's views on the South African government's proposal of integration of traditional healing into the legally recognised national health system. The findings of this study indicates that the world view in which indigenous healing practices are entrenched, has a lot of influence on future relations with western practitioners (Melato, 2000). According to Melato (2000), indigenous African worldview informed by cultural relativism, sees illness and health as well as ancestors and God as interconnected and existing in a state of balance. Based on this view, healing must be approached from the worldview of the patient and that of his/her cultural group.

According to the results of the study done by Melato, indigenous healers perceive themselves as equal to western practitioners because of their training and ability to heal a variety of illnesses. In a study done by Sorsdahl, Flisher, Wilson and Stein (2010) on traditional healers' attitude and belief regarding referral of the mentally ill to western doctors in South Africa, many indigenous healers reported a desire to collaborate with western practitioners. Also in a study done by Melato (2000) indigenous healers perceived integration as a source of unity and recognition. Although most of indigenous healers reported a desire in the collaboration with western practitioners, indigenous healers believe that western practitioners do not want to work with indigenous healers because they do not view them as effective and valuable health practitioners (Sorsdahl et al., 2010).

Melato (2000) explained in the findings of the study that there is still a mind-set of mistrust and suspicion about western trained professionals from indigenous healers. According to Melato (2000), the general impression of indigenous healers is that by working in the same environment with western-trained practitioners, the indigenous healing system could lead to possible extinction. With regards to referring mentally ill patients to indigenous healers by western trained practitioners, many indigenous heelers reported that referral will be made to a more powerful indigenous healer or one who has access to different or better quality ingredients to make the *"muti"* (the medicine used to treat patients by indigenous healers). In a study done by Sorsdahl et al., (2010), indigenous healers expressed the view that western health care practitioners harboured feelings of mistrust towards indigenous healers and were reluctant to form partnership.

According to Sorsdahl et al., (2010), there are advantages of referring patients to indigenous healers, the few advantages of referring mentally ill patients to western trained practitioners focused on treatments that were not always specific to psychiatry. Indigenous healers reported that mentally ill patients are often violent, aggressive, and destructive. This was believed to hinder the ability of the patient to take medication prescribed by the indigenous healer. According to indigenous healers, western trained practitioners are in a possession of an injection that calms the patient down, allowing for

the indigenous healer to administer "muti" which has the capability of healing the patient of their mental illness (Sorsdahl et al., 2010). Melato (2000) believes that indigenous healing system and western healing system working side by side seems to be the only form of integrations which could profit all the citizens in the country.

2.6. Theoretical framework: An Afrocentric perspective

Bojuwoye and Sodi (2010) pointed out that different societies have their own way of understanding and describing various illnesses. In Africa, people interact with one another not on the basis of how things are, but how they perceive them. Africans believe ill-health to have material, moral, supernatural and pre-natural causes which can be determined by both physical observation and divination (Ezeabasili, 1977). According to Dlamini (2006), health care in South Africa is such that it encompasses various healing systems, namely; the western system based on science; the traditional healing system based on indigenous knowledge systems; and, a holistic approach to health care.

In the present study, the researcher was guided by an Afrocentric theoretical framework. The Afrocentric perspective examines topics with the eye of African people as subjects of historical experiences. It seeks to re-locate the African person as an agent in human history in an effort to eliminate the illusion of the fringes (Asante, 2003). The perspective views the manifestations of all forms of ill-health as a result of conflicts between the patient and other individuals, dead or alive, spirits, and the non-material forces that pervade society (Mkhize, 2003).

CHAPTER 3: RESEARCH METHODOLOGY

3.1 Introduction

The purpose of this chapter is to describe the research methodology that was used in the present study. That is, the research design used in the study, sampling procedures that were followed, data collection and data analysis. Ethical considerations for the study are also presented in this chapter.

3.2 Research design

A qualitative research design was adopted in the present study. According to Kobus (2010), qualitative research is based on a naturalistic approach that seeks to understand phenomenon in context. The researcher does not attempt to manipulate the phenomenon of interest. Since the process of meaning construction differs from person to person, and from context to context, it was important for this study to adopt a qualitative design and to ask open-ended questions, so as to have a deeper understanding of the conceptualisation of mental illness by VhaVenda indigenous healers. Babbie and Mouton (2010) state that through open-ended questions one engages more intimately with the phenomenon being studied, because it enables rich, open-ended data, which could be subjected to further clarification and ratification. Clarification and ratification are two very important concepts inherent in qualitative research. They allow one to engage more deeply with the phenomena, as participants can be asked to clarify their responses and provide more clear and in-depth responses (Neuman, 2006).

Specifically, the case study method is adopted for the present study. According to Fouche (2002), a case study is an exploration or in-depth analysis of a single or multiple cases through detailed data collection methods that involve multiple sources of information. For the purpose of the present study, multiple cases were chosen and studied so that comparisons could be made between these cases (Mark, 1996).

3.3 Sampling and setting

Non-probability sampling was used in this study. According to Welman, Kruger and Mitchell (2005), in some communities, especially those in developing countries, the only feasible way to find its members is by asking other members. Participants were selected through snowball sampling for the present study. Sampling continued until data saturation occurred (N=10), meaning when additional analysis of the data brings redundancy and reveals no new information (Morse, 1995). Snowball sampling involves approaching few known individuals from the relevant population and those individuals would then act as informants and identify other members that would be relevant to the study (Welman et al., 2005).

Based on snowball sampling, a set of relevant individuals is identified so that the sample, like a rolling snowball, grows in size till a point of saturation is reached (Welman et al., 2005). In the case of the present study, the researcher asked the first indigenous healer known to her, where to find other indigenous healers. The sample was recruited from Vhembe District in Limpopo Province South Africa, an area where the researcher was born and bred. Vhembe district is located in the Northern part of Limpopo Province and shares boarders with Capricorn, Mopani District municipalities in the eastern and western directions respectively. The sharing of boarders extends to Zimbabwe and Botswana in the North West and Mozambique in the east-south through the Kruger National Park respectively (Vhembe District Municipality, 2013/2014). The District covers 21 407 square km of land with total population of 1 294 722 million people according to Stats SA, 2011.
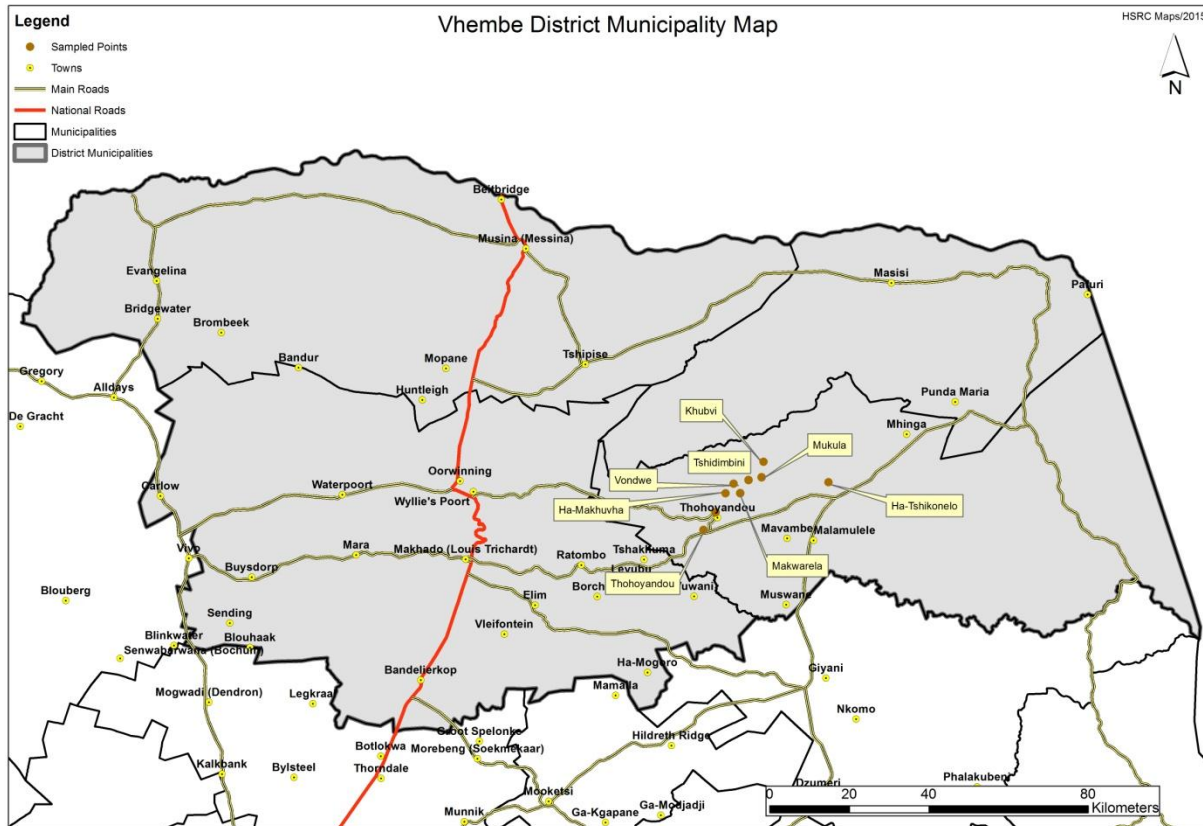
Figure 1 Map Vhembe District, Limpopo Province

3.4 Entry negotiation

It is very important to gain permission to enter the field (Devos et al,. 2007). Before data was collected for the present study, the researcher gained permission to enter the field from VhaVenda Traditional Healers Association.

3.5 Data collection

Data for this study was collected through the use of in-depth semi structured one-to-one interviews (see Annexure 1a: Interview guide – English version; and Annexure 1b: Interview guide – Tshivenda version). According to De Vos, Strydom, Fouche and Delport (2005), semi structured one to one interviews give both the researcher and the participants more flexibility, and are suitable where the researcher is mainly interested

in complexity or process, or where an issue is controversial or personal. Before data collection began the researcher verbally explained the research to the participants. The aims and purpose of the study were also explained to the participants. If they agreed to participate, a date and time was set up to conduct the interview. Where participants were immediately available to be interviewed, they would be presented with an informed consent form (Consent form to be signed by the participant – English version; and, Annexure 4b: Consent form to be signed by the participant – Tshivenda version) to sign before proceeding with the interview. The interviews were recorded with a tape recorder after the participant had given consent for the interviews to be audio taped. This was done by reading the consent form to the participant and asking them to sign if they agreed to participate and to be tape recorded. The interviews were conducted in Tshivenda as preferred by the participants. The recorded interviews were transcribed and later translated into English by an independent English expert before the data was analysed. Furthermore, the translated versions of the transcripts were again translated back to the original language by two independent language experts to ensure reliability. This process ensures that all data is accurately captured, and enhances the credibility and dependability of the study (Brislin, 1970).

3.6 Trustworthiness

In order to ensure that the results of the contemplated study have scientific merit, the following qualitative research principles were observed:

3.6.1 Credibility

One of the key criteria addressed by positivist researchers is that of internal validity, in which they seek to ensure that their study measures or tests what is actually intended (Shenton, 2004). The qualitative equivalent of this concept is credibility, and it deals with the question raised by Shenton (2004): How congruent are the findings with reality? This is the alternative to internal validity, in which the goal is to demonstrate that the inquiry was conducted in such a manner as to ensure that the subject was accurately identified and described (De Vos et al., 2005). Shenton (2004) makes the following

provisions that may be used by researchers to promote confidence that they have accurately recorded the phenomena that is being investigated. These include the development of an early familiarity with the culture of participants. In the present study, the researcher ensured credibility of the results by spending some time with the participants for this study to acquire relevant data. This meant that there was a relationship of trust between the researcher and the participant.

3.6.2 Transferability

Lincoln and Guba (1985) propose this as the alternative to external validity or generalizability, in which the burden of demonstrating the applicability of one set of findings to another context rests more with the investigator who would make the transfer (De Vos et al., 2005). According to Shenton (2004), transferability is concerned with the degree to which research findings of one study can be transferred to another context. This calls for researchers to provide detailed descriptions of their methodology for example data collection and the phenomenon that they are investigating. If there are enough similarities between the two situations, readers may be able to infer that the results of the research would be the same or similar in their own situation (Shenton, 2004). In this study a detailed account of the theoretical framework, aims of the study, and research area is provided. Similarly, a detailed description of the data collection and analysis processes is provided. Based on these considerations, the findings of this study could potentially be transferable to similar people in similar settings (Silverman, 2005).

3.6.3 Dependability

This is the alternative to reliability, in which the researcher attempts to account for changing conditions in the phenomenon chosen for study as well as changes in the design created by increasingly refined understanding of setting. This represents the set of assumptions very different from those shaping the concept of reliability (De Vos et al., 2005).

3.6.4 Conformability/Neutrality

Neutrality refers to the degree to which the findings are a function solely of the informants and conditions of the research and not of other biases, motivations, and perspectives. Neutrality is one of the criteria of trustworthiness in qualitative research and is the freedom from bias in the research procedures and results (Krefting, 1991). Qualitative researchers try to increase the worth of the findings by decreasing the distance between the researcher and the informants, for example, by prolonged contact with informants or lengthy periods of observation. Similarly, the researcher in the present study ensured the conformability of the results by using only what has been said by the participants during data collection.

3.7 Data analysis

Content analysis was utilised to analyse the data after collection. The basic technique of content analysis involves counting the frequencies and sequencing of particular words, phrases or concepts in order to identify themes (Welman et al., 2005). Again, it involves examining the contents systematically to record the relative frequencies of themes as well as the ways in which these are portrayed (Welman et al., 2005). Patton indicates that the core meanings found through content analysis are often called patterns or themes. The process of searching for such patterns or themes is known as pattern or theme analysis. Accordingly, the researcher embarked on analysis by following the steps discussed below in analysing the data:

Step 1: Prepare the data

This step entailed going through the data collected, listing of the different types of information found and transforming the data into written text or file folders and computer files before analysis started. It also involved translating and transcribing the interviews.

Step 2: Reading and writing memos

This stage involved reading the transcripts in their entirety several times, so as to try and get a sense of the interview as a whole, before attempting to break it into parts. During this process, the researcher listed the data available; performed some necessary editing to make filed notes retrievable. The stage also involved writing memos in the margins of field notes or transcripts. These can be short phrases, ideas or key concepts that occurred to the reader (Creswell, 1998).

Step 3: Develop categories and a coding scheme

This step involved listing and categorising each item in a way that offers a description of what it is about, and identify whether or not the categories can be linked in any way and list them as major categories or themes and minor categories or themes.

Step 4: Testing of coding scheme

This involved checking the coding consistency. The data was evaluated for its usefulness and centrality, that is, the researcher determined how useful the data collected is in illuminating the questions being explored and how central they are to the matter under study.

Step 5: Coding and assessing of consistency

When sufficient consistency was achieved, the coding rules were applied to all texts. After coding the entire data set, consistency was rechecked to ensure reliability.

Step 7: Draw conclusions from coded data

This step involved making sense of the themes or the categories identified and their properties. It involved exploring the properties and dimensions of categories, identifying relationships between categories, uncovering patterns, and testing categories against the full range data (Bradley, 1993).

Step 8: Reporting of the findings

This is the final phase that is regarded as the primary mode for reporting the results of the research. An interesting and readable report was provided sufficient description of the matter under study to allow people to understand the basis for an interpretation and the description. For the study to be replicable, the analytic procedures and processes have to be reported as truthfully as possible (Patton, 2002). The data is presented in text. The results will be disseminated through papers that will be published from the present study.

3.8. Ethical considerations

3.8.1 Permission to conduct the study

Before conducting the study, ethical clearance was requested from The University of Limpopo's Research Ethics Committee (see Appendix 4: Letter of ethical approval). After obtaining ethical approval and permission the researcher commenced with data collection.

3.8.2 Informed consent

Before the interview commenced the researcher ensured consent by informing the respondents about the nature and purpose of the study, the procedure to be used, the reasonable risk and discomforts of participating in the study. The participants were requested to sign a written consent form before participating in the study (See Annexure 3a: Informed consent letter – English version; Annexure 3b: Informed consent letter – Tshivenda version; Annexure 4a: Consent form to be signed by the participant – English version; and, Annexure 4b: Consent form to be signed by the participant – Tshivenda version). Every participant was treated with respect and dignity. The participants were further assured that they are not compelled to continue with the study, and that they were free to withdraw from participating in the study should they feel uncomfortable.

3.8.3 Anonymity and confidentiality

The researcher maintained confidentiality by ensuring that the information given will not be divulged. The principle of anonymity is linked to confidentiality (Bless & Hughson-Smith, 2000). In this study the researcher ensured the participants' anonymity by assuring them that their real names are not disclosed and that their identity is not revealed in the research report.

CHAPTER 4: RESULTS

4.1 Introduction

This chapter presents the findings of this study. The researcher investigated the conceptualisation of mental illness by VhaVenda indigenous healers. Ten participants were interviewed in order to gather sufficient data. The demographic information of the participants is presented in the form of a table (see Table 1). The main themes that emerged from the study were as follows: a). participants understanding of mental illness; b). causes of mental illness; c). types of mental illness; d). signs and symptoms of mental illness; e). diagnoses of mental illness and f). Treatment of mental illness. The chapter is concluded by giving a summary of the findings of the study. As the data was collected in *Tshivenḓa,* some of the phrases might not be intelligible, or might be difficult to understand when translated into English hence explanations is provided, where necessary.

4.2 Demographic information of participants

Table 1: Demographic information of participants

Participant no:	Gender	Occupation	Residential Area
1	Male	Nurse	Tshidimbini
2	Female	Unemployed	Ha-Makhuvha
3	Male	Unemployed	Ha-Tshikonelo
4	Male	Unemployed	Mukula
5	Male	Unemployed	Tshidimbini
6	Male	Unemployed	Makwarela
7	Female	Unemployed	Vondwe
8	Male	Unemployed	Kubvi

9	Male	Unemployed	Kubvi
10	Male	Unemployed	Thohoyandou

The table above shows the demographic information of the participants which include their gender, age, occupation and residential address. All the participants (the indigenous healers) were drawn from Vhembe district. Most of the participants were unemployed since they had to leave their jobs and accept the calling to become an indigenous healer. All the participants were Tshivenda speaking.

Table 2: Themes and subthemes

Theme number	Main Theme	Subtheme
1.	Participants' understanding of mental illness **(4.3)**	Mental illness viewed as behavioural problem **(4.3.1)**
		Participant understanding of mental illness as a curse or as a result of witchcraft **(4.3.2)**
		Mental illness as something that happens spontaneously **(4.3.3)**
		The participant understanding of mental illness as the disturbance in the mind or thought process **(4.3.4)**
2.	Types of mental illness **(4.4)**	Mental illness according to the cause **(4.4.1)**
		Symptomic-metal illness **(4.4.2)**
		Seasonal mental illness **(4.4.3)**
		Epilepsy as a mental illness **(4.4.4)**
3.	Signs and symptoms of mental illness **(4.5)**	Talking and laughing alone **(4.5.1)**
		Taking off the clothes **(4.5.2)**

		Hearing voices **(4.5.3)**
		Seeing things **(4.5.4)**
		Untidiness **(4.5.5)**
		Violence/ beating people **(4.5.6)**
4.	Diagnosis of mental illness by indigenous healers**(4.6)**	
5.	Causes of mental illness(4.7)	Stressful life events or problems **(4.7.1)**
		Heredity **(4.7.2)**
		Witchcraft or evil spirits **(4.7.3)**
		Poisoning **(4.7.4)**
		Accidents/ Trauma **(4.7.5)**
		Dagga **(4.7.6)**
6	Treatment of mental illness **(4.8)**	

4.3. Participants' understanding of mental illness

4.3.1 Mental illness viewed as a behavioural problem

When the participants were asked about their understanding of mental illness, it seemed their understanding varied based on their conceptualisation of the source of the illness and what the illness does to a person's behaviour. Most of the participants perceived mental illnesses as something that is displayed through a person's behaviour. One participant mentioned that people with mental illness will do things that a normal person cannot do. The following extracts further illustrate this understanding:

> *"That person won't want to know who is this and that. Depending on different people, because sometimes you may find a person with mental illness behaving like a child"* **[Participant 2]**

"….or he wants to do things that a normal person cannot do" **[Participant 4]**

"Mental illness is when a person is behaving in an unusual way. These things that…ehh…things that a normal person cannot do". **[Participant 6]**

"Maybe when we know that a person must live or think or his behaviour is different from other people" **[Participant 7]**

"…mental illness is…eh...like when you see a person playing with their fingers, pointing here and there, laughing alone, and also collecting dirty things" **[Participant 8]**

Based on the above extracts, it could be suggested that mental illness is understood by participants as a condition that has some behavioural manifestations that are not considered normal within their social context. In other words, mental illness is understood and described in the context of the socio-cultural context of the individual affected.

4.3.2 Participants' understanding of mental illness as a curse or a result of witchcraft

The extracts below suggest that some of the participants understand mental illness as a curse or a result of witchcraft:

"According to our understanding of mental illness Tshivenda culture is a sickness that comes when a person has been bewitched" **[Participant 1]**

"…and even being bewitched and evil spirits are instilled in you. That is what I understand." **[Participant 7]**

"They bewitch you and make you have mental illness, and from there the person will start talking alone or calling someone's name, or saying "I'm coming now", or "I didn't take everything" or "I will come tomorrow" then you will know that that person has mental illness" **[Participant 8]**

"In our tradition that person is cursed with evil spirits." [**Participant** 9]

From the extracts above, it does appear that the participants' understanding of mental illness is linked to what is perceived as the source of the mental illness. In this case, external factors like a curse or evil intentions of others are perceived as the cause of mental illness.

4.3.3 Mental illness as something that happens spontaneously

In some cases mental illness was viewed as something that was spontaneous; it happened unexpectedly. The idea that mental illness is spontaneous was argued by participant 2 below.

"My understanding of mental illness is that mental illness is an illness that happens unexpectedly. It comes unexpectedly when a person is not aware." [**Participant 2**]

"Mental illness is something that happens unexpectedly and people don't realise quickly." [**Participant 5**]

The extract above by participant 5 lends support to the idea of mental illness as something that happens unexpectedly. In other words, people in this case do not get any form of warning prior to getting mentally ill.

4.3.4 Participants' understanding of mental illness as disturbance in the mind and thought process

Mental illness was understood by some participants as something that has to do with the mind and the thought processes. The following extracts illustrate this view:

"Mental illness is when one's thoughts and mind are disorganised" [**Participant** 3]

"It implies that the person's mind is no longer working properly." [**Participant** 3]

"Mental illness in our tradition is a disease that makes a person to think in the way that he/she is not supposed to think." [**Participant** 9]

"Mental illness is when a person's mind is messed up or when his head is messed up." [**Participant** 7]

Based on the above statements, it can be suggested that mental illness is understood and described by most participants as a condition that significantly disturbs an individual's thought and cognitive processes.

4.4 Types of mental illness

Most of the participants did not seem to make a distinction of the different types of mental illness. This is reflected in the extracts below:

"Here in Tshivenḓa we don't really have specifications on different types of mental illness that we can really say." [**Participant** 1]

"According to us indigenous healers, we may not say that there are types or what." [**Participant** 7]

"Eh… we don't have the names of mental illness, we can only see that a person has mental illness, we take all mental illness the same , that a person has mental illness. We don't differentiate; we just use different ways of treating mental illness….." [**Participant** 10]

Based on the above extract it can therefore be suggested that participants do not have an elaborate nosological system that distinguishes the different types of mental illness. Instead of giving names to the illnesses, the participants tended to describe the illness based on what is perceived as the cause. This is further reiterated in the section below.

4.4.1 Mental illness according to what is perceived as the cause

The identification of the types of mental illness according to the cause is presented below:

"There is the first type of mental illness which according to us and how we heal, we would say that a person has evil spirits." [**Participant 4**]

"The other kind is when one is mentally ill, maybe because that person inherited mental illness, when the whole family has mental illness. That means it's in the genes of that particular family" [**Participant 4**]

"There is mental illness that comes because of problems, like I mentioned when we started, when a person has a big problem that he cannot solve, he can have mental illness." [**Participant 6**]

"Another type of mental illness is what we hear other religious people saying that a person is sick, his/her brains are no longer at the right place. The front brains have gone to the back and the back has gone to the front, maybe it's a person that was injured during a car accident or whose head was injured. We take that as another mental illness that makes a person not to think the way they are supposed to." [**Participant 9**]

From the extracts above it is evident that mental illness for most participants is better explained in terms of what is perceived as the cause. In this context, it appears that there is no elaborate nosological system that gives names to the different mental illnesses.

4.4.2 Symptomatic mental illness

Symptoms seemed to also help the participants in identifying and describing mental illness as reflected in the extracts below:

"There is mental illness of hearing voices; some other people can hear them at night when they are sleeping." [**Participant 5**]

"There is mental illness where by a person just takes off the clothes, where a person always takes off the clothes in public." **[*Participant* 6]**

"There is another mental illness that makes a person to go around beating up people, or running after people. Running after people and beating them up." **[*Participant* 6]**

Based on the above statements, it does appear that participants recognise the existence of different forms of mental illness according to the symptoms that are displayed.

4.4.3 Seasonal mental illness

Some participants seemed to link some forms of mental illness to season of the year. This is reflected in one of the participants' extract below:

"There is mental illness that happens in season, where there is time that a person's mental illness starts. You will hear others saying that its September mental illness starts because the trees are having a new leaf." **[*Participant* 6]**

4.4.4 Epilepsy as a mental illness

For some participants, *tshifakhole* (epilepsy) is another type of mental illness. This is reflected in the following statements:

"It's just that you will find people who start speaking things that don't make sense after having that disease that we call 'tshifakhole'- that disease of falling. When they wake up they don't remember anything, and when they wake up they can start beating up people. This can also be a type of mental illness and also how people call it from way back." **[*Participant* 1]**

"Ehh…sometimes there is epilepsy, it's also another type of mental illness that comes in different ways that is epilepsy" **[*Participant* 8]**

The above extracts and the ones below seem to suggest that there is no clarity as to whether or not epilepsy is a mental illness. Whilst some participants perceived epilepsy as another type of mental illness, others were of the view that mental illness and epilepsy are similar. Some of the participants even went further to suggest that the remedies they use to heal epilepsy can also be used for mental illness. The following extracts illustrate this:

> *"And when we see people the way they are; now these sicknesses are interwoven, when we check epilepsy we may observe some languages that a mentally ill person has. And this shows that all these things are slightly similar, but these sicknesses differ in terms of symptoms…..but in Tshivenḓa the remedies for epilepsy may also be used for mentally ill patients….."*
> [*Participant* 3]

> *"No…we cannot say that it is mental illness because this disease doesn't happen all the time."* [*Participant* 4]
> *"Epilepsy is not mental illness. Epilepsy is epilepsy and mental illness is mental illness….. Even healing processes are different from that of mental illness".*
> [*Participant* 2]

4.5 Signs and symptoms of mental illness

A number of signs and symptoms that characterise mental illness were identified and described by the participants. In this section, the different signs and symptoms as perceived by the participants are presented

4.5.1 Talking and laughing alone

According to the participants, talking and laughing alone, and doing things that do not make sense is one of the common indicators of mental illness. This is reflected in the following statements:

> *"People who have mental illness you will mostly find them talking about things that don't make sense or they tend to talk and laugh alone."* **[Participant 1]**

> *"You may find a person starting to talk alone, just talking alone."* **[Participant 2]**

> *"You may also find that mentally ill person talking and laughing alone, like he is with other people but he is alone. Then you will be able to see that this person has mental illness."* **[Participant 4]**

> *"…he talks alone and laughs alone and you won't see what he is laughing at…."* **[Participant 5]**

> *"…you may find him talking alone and pointing as if there is a conversation between him and the other person."* **[Participant 6]**

From the extracts above, it is evident that, deviant behaviour is reflected in actions like talking alone or laughing inappropriately hence considered as a sign of mental illness.

4.5.2 Taking off clothes:

Participants also indicated that some of the signs and symptoms of mental illness are shown when the affected individual takes off clothes in public.This is reflected in the following statements:

> *"Most of the mentally ill people are those that take off their clothes in public, and they also eat their feces."* **[Participant 1]**

> *"Some even take their clothes off and remain naked and you will find that person being so ignorant. To him there's nothing wrong about it."* **[Participant 7]**

"Another thing is ehh…that person will also like taking off his/her clothes and walk around naked." [***Participant* 8**]

Based on the above statements it confirms that the participant views taking off of the clothes in public as a sign and symptom of mental illness.

4.5.3 Hearing voices

Other participant pointed out that hearing voices can be considered as a sign and symptom of mental illness.

"…he can hear voices in his ears, hearing voices of so and so…." [***Participant* 1**]

"You can also hear her saying that there is a person calling me or saying that she is called somewhere, there is someone saying that she must come right now…." [***Participant* 4**]

"Others hear things, or voices because you will hear them saying that they are called. But when you are seated with him you don't hear anything." [***Participan*t 7**]

Based on the above statements, it does appear that hearing voices was considered as a sign and symptom of mental illness. The participant here went further by stating that the mentally ill will indicate that they are hearing voices and when seated with that person you won't hear those voices.

4.5.4 Seeing things

Some participants pointed out that seeing things that cannot be seen by other people is considered one of the signs and symptoms of mental illness. This is reflected in the extracts below:

"It sometimes happens that this person can start shouting saying that there are people calling me….there are people that I can see…" [**Participant 4**]

"…another thing is you find that person screaming saying that he is seeing people that are not visible to other people." **[Participant 9]**

Based on the above statements, it does appear that seeing things that others cannot see is considered a sign and symptom of mental illness.

4.5.5 Untidiness

Some participants also indicated that when the person is always dirty it can be associated with mental illness. This was presented by participant 7 below:

"Another thing is that you can find that he doesn't like bathing; he can tie himself with useless things in his whole body. You can also find him picking up litter and store it, to him that is very useful." **[Participant 1]**

"You will find him always dirty. It is then that you will see that this person has a mental illness." **[Participant 7]**

Based on the above extracts it can be suggested that untidiness is considered as one of the signs and symptoms of mental illness by participants.

4.5.6 Violence/beating people

Some participants indicated that some individuals with mental illness tend to be violent towards other people:

"Some people with mental illness you will find them beating up people." **[*Participant* 10]**

"Some will just beat up people; it means that it happened in a way that he wants to beat up people." **[*Participant* 2]**

From the extracts above, it can be suggested that violent behaviour is one of the symptoms that indicate the presence of mental illness.

4.6 Diagnosis of mental illness by indigenous healers

According to the participants interviewed, a number of procedures are used to diagnose mental illness. For example, observations and the use of *mufuvha or ṱhangu* (divination bones) are common procedures that the participants use to diagnose mental illness. This is reflected in the following statements:

"….when we talk about mental illness to us indigenous healers, it is when we observe in this manner, firstly we throw bones and determine if it is related to mental illness" [***Participant* 3**]

"As indigenous healers, we see through our bones that a person has mental illness and what caused that mental illness." [***Participant* 6**]

The above statements indicated that participants can see if the person has mental illness through mufuvha *or ṱhangu.* Participant 6 also went further to point out that the divination bones help to detect the cause of the mental illness. This is illustrated in the extract below:

"So we take mufuvha or ṱhangu [divination bones] and throw them down and see what kind of mental illness the person has." [***Participant* 9**]

The claim that indigenous healers can detect an individual's mental illness by divination bones and other diagnostic procedures is further illustrated in the extracts below:

"We can also see that a person has mental illness by his/her behaviour" [***Participant* 6**]

"Ehh…that is why I mentioned that why I mentioned that sometimes you will see by action…." [***Participant* 8**]

4.7 Causes of mental illness

It was evident that participants had different perceptions on what causes mental illness. The participants attributed mental illness as a direct consequence of being bewitched or cursed, dagga smoking or accidents, stressful-life events and even heredity.

4.7.1 Stressful life events or problems

Participants' explanation of the cause of mental illness includes stressful-life events or problems. This is reflected in the extracts below:

> *"Sometimes mental illness can be caused by problems, sometimes a person can be involved in a situation that he cannot   come out of. So if that person thinks too much it makes that person to have mental illness."* **[*Participant* 2]**

> *"….if in a family there is a problem between a man and a woman; it is possible for a person to develop mental illness…."* **[*Participant* 3]**

> *"It is mental illness that is due to stress that a woman is going to have a child of someone who doesn't want a child…."* **[*Participant* 4]**

> *"Mental illness can be caused by problems, more especially if the problems is too big and unsolved*" **[*Participant* 6]**

> *"If problems are numerous, or a person experiences numerous problems or even one problem that he fails to solve, such a problem may deepen to an extent that he starts getting mentally disturbed"* **[*Participant* 7]**

Based on the above extracts, it can therefore be suggested that mental illness is perceived as a condition that results from stressors such a marital conflict

4.7.2 Heredity

Most participants elaborated that mental illness can be carried out in the genes or can be a result of heredity. For example, if there is or was a member of the family that

has/had mental illness in the family, mental illness will be carried out to other generations in that family. This is presented below.

"That is why you will find that among family members in that family members, people in that family have mental illness, it passes on to generations and generations" **[Participant 1]**

"Some mental illness is from the family. Back at the family if there was someone with mental illness it means that it will pass onto others. And you will find that in that family there will be someone with mental illness, it will be inherited by subsequent generations." **[Participant 2]**

"In cases where you find the whole family with mental illness, it means that they inherited it genetically, so it's in their genes." **[Participant 4]**

"…if in the family someone in that family has or had mental illness it can be passed into the next generation after that person with mental illness dies or when the mentally ill is still alive…" **[Participant 5]**

"Mental illness can also be transmitted genetically; you may find that mental illness is in that family, it stays in the blood of that particular family" **[Participant 6]**

"….when they have inherited mental illness from the parents, or from generations before and mental illness continues in the family, and it becomes a family of mental illness because they have inherited it." **[Participant 9]**

From the extracts above, it is evident that participants viewed heredity as one of the causes of mental illness. This was also indicated when participants mentioned that mental illness is transmitted genetically and this will be passed into the next generations.

4.7.3 Witchcraft or evil spirits

Some of the participants perceived mental illness to be a direct result of witchcraft or evil spirits. The reasons for witchcraft included envy, jealousy or being motivated by other evil intentions like having to hurt the victim's parents. This understanding is reflected in the following statements:

"….in Tshivenḓa culture, people can put evil spirits in a person's body; they are able to wickedly incapacitate a person out of envy in that way you will find that person to have mental illness…" **[*Participant* 1]**

"A person is able to make one suffer from mental illness…." **[*Participant* 2]**

"Yes it can be caused by witchcraft…" **[*Participant 4*]**

"Mental illness is caused by spirits…." **[*Participant 5*]**

"…most of the time, you are a problem in the village. They will bewitch you, you may be stealing too much or maybe you have raped or what." **[*Participant* 6]**

"…even witchcraft; they can do it these people." **[*Participant* 7]**

"….you can steal and those people bewitch you." They bewitch you to make you have mental illness….." **[*Participant* 8]**

"By evil spirits we mean….we have a belief that it is possible for people to take spirits of the living things and curse that person with evil spirits…people that hate you….people who don't like you. When they have cursed you, you will see yourself in a situation that you are not aware of yourself, you are also not aware of what you are saying, you also not aware of what you are seeing. When it is evening you are not aware, you also not aware that you are sitting in the sun, you are also not aware if there is fire. That is when you are in a situation that you are not aware of yourself….that is mental illness." **[*Participant* 9]**

"Sometimes it may be because the person has been cursed with evil spirits." **[Participant 10]**

Based on the above extracts, it does appear that a number of participants tend to attribute mental illness to supernatural forces. Some participants indicated that mental illness is a result of witchcraft. Participants indicated this this can be done for a number of reasons, sometimes it can be because of envy or revenge.

4.7.4 Poisoning

Some participants explained that mental illness can also be due to poisoning. They mentioned that people put poison in the food so that after eating the victim can develop mental illness. This causal explanation is reflected in the extracts below:

> *"They pour medicine in the food and when he eats that food he will have mental illness."* [**Participant** 6]

> *"They can give you something to eat so that you can have mental illness"* [**Participant** 9]

> *"Or they can pour medicine on food and after eating you get mentally ill"* [**Participant** 7]

From the above it can therefore be suggested that participants perceive poison to be the cause of mental illness. This again, suggests that mental illness is attributed factors external to the individual

4.7.5 Accidents/Trauma

Some participants also reported that a person can have mental illness after being involved in a car accident. If that person's head gets injured it is reported that he/she can have mental illness

> *"....sometimes it could be as a result of car accident, or sometimes knocked down by a bicycle…"* [**Participant** 3]

"Even labour pains can cause mental illness; some woman here gave birth and started having mental illness. It means that the labour pains overcame her and she ended having mental illness." [**Participant** 6]

"Sometimes you can be involved in a car accident and have mental illness because of that accident." [**Participant** 8]

"…maybe it's a person that was injured during a car accident or whose head was injured. We take that as another mental illness that makes a person not to think the way they are supposed to." [**Participant** 9]

Based on the above extracts it can be suggested that participants perceive mental illness to be a result of occurrences like accidents and trauma. For example, if a person gets involved in a car accident, this can result in some form of mental illness.

4.7.6 Dagga

Some participants mentioned that the use of dagga or drugs can lead to mental illness. They further expressed a view that these substances disturb brain functioning, thus leading to some form of mental illness. This causal explanation of mental illness is reflected in the extracts below:

"…dagga is not taken that way but as the world opens up and opens up we hear that it damages the brains and it ends up making the person to have mental illness." [**Participant** 1]

"….you will see them it's a child from another household using drugs; you will be able to see that if he continues using he will have mental illness." [**Participant** 2]

"Drugs can really cause mental illness." [**Participant** 2]

"Even weed can cause mental illness." [**Participant** 5]

Sometimes it may also happen because the person is using things that made him/her to be mentally ill, an example of a person smoking dagga which can cause mental illness. **[*Participant* 10]**

Based on the above extracts, it could be suggested that substance use can lead to some form of mental illness.

4.8 Treatment of mental illness

With regard to treatment, most participants considered mental illness to be a condition that can be treated through indigenous remedies and practices. This is reflected in the following statements:

"Yes, they can be cured by inhaling the remedy and those things will come out and they will live a normal life just like everyone." **[Participant 1]**

"That person will be given some remedy to inhale…." **[Participant 1]**

"When a person has spirits we use remedies that go hand in hand with those spirits… meaning, it's only remedies related to those spirits." **[Participant 4]**

"The medicine used to cure mental illness is a fruit used to be eaten a long time ago, a Tshivenda fruit. That fruit can cure a person and that person will never have mental illness again." **[Participant 4]**

"So when a person has been done such things…it means that we must make some herbs and a wristlet and some water and he will go and call his ancestors under a big tree. And tell them to stay with him and those things that were cast to him to remain there. After that he must bath his body and that means those things are gone." **[*Participant* 4]**

"That person will be given some remedy to inhale and will be given some soft porridge and he will eat and be healed" **[*Participant* 1]**

The above statements suggest that both traditional medical interventions and some culturally relevant psychological procedures are used to treat mental illness. This suggests that an indigenous healer may be playing the role of medical practitioner and psychologist at the same time.

One participant reported that indigenous healers acknowledge and recognise the role that can be played by other role players in mental health promotion as reflected in the extract below:

> *"But if such a person seeks help from people who can counsel him, people like pastors and fellow Christians such person can improve without any need for medicine."* [*Participant* 3]

Based on the extract above, it can be suggested that indigenous healers see the role of other role players in mental health promotion. The implication here is that there is a need for closer cooperation between indigenous healers and other role players such as western trained health care practitioners and spiritual/faith healers.

4.9 Concluding remarks

The present study comprised 10 participants who are indigenous healers from Vhembe District. All the participants were Tshivenda speaking. It is clear from the present study that the participant's conceptualisation of mental illness varied. Some participants conceptualised mental illness as a curse or a result of witch craft. From the findings of the present study participants also had different perceptions about the causes of mental illness, amongst other causes poison was mentioned as a cause of mental illness. This suggests that mental illness s attributed factors external to the individual.

When it comes to the types of mental illness, the findings of the participants from the present study indicated that in Tshivenda culture they don't have different names that they give to different types of mental illnesses. Therefore, it can be suggested that participants do not elaborate on nosological system that distinguishes the different types of mental illness, instead of giving names to the illness the participants tended to

describe the illnesses based on what is perceived as the cause. Participants also indicated that they identify the different forms of mental illness according to the symptoms that are displayed by the mentally ill.

It was indicated by some participants from the present study that *tshifakhole* (epilepsy) is another form of mental illness, although some participants disagreed about the notion that *tshifakhole* is another form of mental illness, some participants went further by suggesting that the remedies they use to heal *tshifakhole* can also be used for mental illness. The different signs and symptoms that are displayed by the mentally ill persons were also indicated. Deviant behaviour was also considered to be a sign and symptom of mental illness. From the results of the present study, participants indicated a number of procedures used to diagnose mental illness. Participants indicated that they use *mufuvha or thangu* (divination bones) and observation. Participants from the present study considered mental illness to be treated through the use of indigenous remedies and practices. From the findings of it can be suggested that both indigenous medical interventions and some culturally psychological procedures are used to treat mental illness. This suggests that indigenous healers may be playing a role of a medical practitioners and psychologist at the same time form the communities.

CHAPTER 5: DISCUSSION

5.1. Introduction

This chapter discusses findings of the study presented in the previous chapter. It also aims to provide discussion of the themes that emerged from the study. The themes discussed are; a). Understanding of mental illness; b) Causes of mental illness; c) Types of mental illness; d) Signs and symptoms of mental illness; e) Diagnoses of mental illness by indigenous healers; f) Treatment of mental illness.

5.2 Emerging themes

5.2.1 Understanding of mental illness

From the findings of this study, participants' understanding of mental illness varied. Some seem to understand mental illness as something that has to do with the behaviour of the mentally ill. The participants' understanding of mental illness is associated to behaviours that are not considered to be normal within their social context and those behaviours are displayed by the mentally ill. These findings are supported by Koen et al., (2003); Mufamadi, (2001); Mzimkulu and Simbayi, (2006); Robertson, (2006), who indicted that in many parts of Africa, mental illness is understood to be present when an individual shows behavioural signs and symptoms that are perceived to deviate from social norms.

The description of mental illness according to indigenous healers interviewed in the study can be said to be linked to how mental illness is conceptualised in the academic literature. The American Psychiatric Association (2013) in particular, conceptualises mental illness as being a manifestation of a behavioural, psychological or biological dysfunction in the individual. From the findings of the present study; the participants also understood mental illness as a curse or as a result of witchcraft. These findings are consistent with the earlier findings by Mzimkulu and Simbayi (2006) who suggested that in many African communities, witchcraft is commonly believed to lead to mental illness.

5.2.2 Causes of mental illness

Participants in the present study mentioned different causes of mental illness.

(a) Stressful life events

In the present study participants' explanation of the causes of mental illness include stressful-life events and problems. These findings lend support to the results of a study by Aina (2008); Srinivasan and Thara (2001); Kadri et al. (2004) who indicated that a vast majority of people in developing countries attribute mental illness to stressful life events, supernatural phenomena, and heredity. This finding was also supported by Workneh (1980) who indicated that in traditional Oromo thinking, mental illnesses are generally explained as resulting from disturbance in the relationship between people.

(b) Witchcraft or evil spirits

In the present study, the participants' view of the cause of mental illness also included witchcraft or evil spirits. The present results on the possible etiology of mental illness are consistent with the previous studies undertaken in other parts of Africa and internationally. For example, both Musara et al. (1995) and Mutebirwa (1989) in Zimbabwe found that psychosis was believed to be caused by supernatural powers. Similarly, a study conducted in Malaysia by Razali et al. (1996) found that 70% of Malaysian indigenous healers attributed mental illness to supernatural causes such as witchcraft and angered ancestors.

(c) Poisoning

From the findings of this study it is believed that, at times, some people are driven by jealousy and evil intentions to an extent of poisoning those that they envy or hate. These findings lent support Buhrmann (1984) and Ngubane (1977) who indicated that poisoning is one of the popular etiological factors advanced to explain some physical and psychological complaints presented by African patients.

(d) Dagga

From the findings of this study, Participants mentioned that dagga or drugs is viewed as one of the causes of mental illness. They also mentioned that dagga/drugs cause disturbance in the brains which then causes mental illness. A study by Mzimkulu and Simbayi (2006) gave support to the present study by outlining that substance use especially the use of drugs was perceived as one of the causes of mental illness by indigenous healers.

5.2.3 Signs and symptoms of mental illness

In the present study most participants interviewed considered talking and laughing alone, taking off the clothes in public, hearing voices, seeing things, violence or beating people and untidiness as some of the signs and symptoms of mental illness. The result of the present study matched with those of the DSM-V (American Psychiatric Association, 2013). For example the participants conceptualised various kinds of symptoms such as hallucinations, delusions, disorganised speech, grossly disorganised and social dysfunction. A study done by Mufamadi (2001), found that a number of symptoms were associated with mental illness, including; aggression, talking incoherently, isolation, shouting loudly, confusion and strange behaviour, and reported perceived causes such as heredity, witchcraft, sorcery, disregard of cultural norms and spirit possession. . Most of the signs and symptoms presented in the study were found to be similar to those that are done in other African Countries. It can therefore be argued that that although there might be slight differences in the interpretation of maladaptive behaviour, there are striking similarities in the conceptualisation of mental illness in different parts of Africa (Mufamadi & Sodi, 2010)

5.2.4 Diagnoses of mental illness by indigenous healers

From the findings of this study participants interviewed indicated that they can see if someone has the mental illness through their behaviours and through the divination bones. According to Buhrmann (1984) and Ngubane (1977), divination bones are also reported to be used in other parts of Africa to diagnose illnesses.

5.2.5 Treatment of mental illness

From the findings of the present study participant interviewed mentioned that mental illness can be cured by indigenous remedies and practices. Some of the practices indicated by participants were inhaling of herbs and steaming. This is supported by Hadebe (1986) who found that some indigenous healers' interventions strategies at a physical level include the use of namesis, anema, steaming, taking medicine nasally and vaccination. The findings of this study suggest that both traditional medical interventions and some culturally relevant psychological procedures are used to treat mental illness. This suggests that an indigenous healer may be playing the role of medical practitioner and psychologist at the same time.

5.2.6 Types of mental illness

From the findings of this study most of the participants did not seem to make a distinction of the different types of mental illness. It can therefore be suggested participants do not elaborate nosological system that distinguishes the different types of mental illness. Instead of giving names to the illnesses, the participants tended to describe the illness based on what is perceived as the cause of the illness.

5.3 Implications for theory

Bojuwoye and Sodi (2010) pointed out that different societies have their own way of understanding and describing various illnesses. In Africa, people interact with one another not on the basis of how things are, but how they perceive them. According to Dlamini (2006), health care in South Africa is such that it encompasses various healing systems, namely; the western system based on science; the traditional healing system based on indigenous knowledge systems; and, a holistic approach to health care. The present study was guided by Afrocentric theoretical framework. The Afrocentric perspective examines topics with the eye of African people as subjects of historical experiences. It seeks to re-locate the African person as an agent in human history in an effort to eliminate the illusion of the fringes (Asante, 2003). The perspective views the manifestations of all forms of ill-health as a result of conflicts between the patient and other individuals, dead or alive, spirits, and the non-material forces that pervade society (Mkhize, 2003).

Based on the results of this study, it can be suggested that some participants tend to view mental illness as a curse caused by evil spirits. This indicates that participants viewed mental illness as a condition that is a result of supernatural causes. Participants also perceived mental illness as a behaviour that is not acceptable in terms of the prevailing societal norms. According to Ezeabasili (1977), Africans believe ill-health to have material, moral, supernatural and pre-natural causes that can be determined by both physical observation and divination. From the results of this it was indicated by participants that they diagnose mental illness by the use of *thangu* (divination bones) and also from observing the patients behaviour. Treatment and healing from the Afrocentric approach relies on the indigenous knowledge system. The results further revealed that indigenous healers commonly use herbs and some indigenous practices like rituals to treat mental illness. The indigenous healers indicated that for treatment of mental illness, they give the mentally ill person remedies to inhale, some herbs and also given a wristlet to wear. They also indicated that the mental ill person also bath the body with remedies in the water and given soft porridge to eat.

CHAPTER 6: SUMMARY AND CONCLUSIONS

6.1 Summary

The aim of the present study was to explore the conceptualisation of mental illness by VhaVenda traditional healers. The objectives of the study were:

- To establish what VhaVenda indigenous healers understand as mental illness;
- To determine the types of mental illness identified by VhaVenda indigenous healers;
- To determine what indigenous healers perceive as the signs and symptoms of mental illness.

Based on the findings of the study, the following six themes emerged: a). Participants' understanding of mental illness; b). Causes of mental illness; c). Types of mental illness; d). Signs and symptoms of mental illness; e). Diagnosis of mental illness by indigenous healers; and, f). Treatment of mental illness: The six themes were further broken down into subthemes. The results are discussed in the context of the emerging field of African psychology and the calls for greater recognition of indigenous healers in mental health care provision in developing countries like South Africa. From the findings of this study it does appear that mental illness is perceived by the participants as a result of a number of factors, with witchcraft as the main cause. This suggests that mental illness is a culturally conceptualised condition that is perceived to be brought about by external agents like supernatural factors and evil intentions of others. This causal explanation of mental illness appears to contradict the popular Western notion of mental illness that tends to perceive this condition as a result of the individual's inner psychological forces. Generally, the participants perceived mental illness as a condition that is associated with behaviours that are not considered to be normal within their social context.

The findings of the present study further suggest that the participants do not have an elaborate nosological system that distinguishes between the different types of mental illness. Instead of giving names to the illnesses, the participants tended to describe the illness based on what is perceived as the cause. In view of the the above findings, it can be suggested that both traditional medical interventions and some culturally relevant psychological procedures are used to treat mental illness. This suggests that an indigenous healer is perceived as playing the role of medical practitioner and psychologist at the same time in the communities where they practise.

6.2 Limitations

The following were some of the limitations of the present study:

- Firstly, the nature of the investigation required the researcher to use snowball sampling to obtain the required number of participants. This approach made it difficult to get the required number of traditional healers to participate in the study.
- Secondly, the interviews were conducted in Tshivenda and were later translated into English by a language expert. This process may have resulted in some of the cultural nuances that are embedded in language being lost in the process of transforming the data from one language to another.
- Thirdly, pretesting was not done amongst the targeted participants.
- The sample used comprised traditional healers drawn from a small rural community in Vhembe district. Given the sample size, it is therefore not possible to generalise the findings of the present study to the bigger VhaVenda people or the South African population.

6.3 Recommendations

- From the findings of the current study, it is evident that indigenous healers draw form an Afrocentric perspective with regards to their approach to the treatment of mental illness. It therefore important for future studies to understand and appreciate the critical role that culture plays in the etiology and treatment of mental illness.

- It is evident that indigenous healers play an important role in providing mental health services to people in rural communities. Given the findings of this study, it can be recommended that indigenous healers need to be recognised as mental health providers since they provide culturally appropriate treatment to people in their communities. It is hoped that the promulgation of the Traditional Health Practitioners Act (2007) will help in this direction addressing; one of its purposes was to establish the Interim Traditional Health Traditional Council of South Africa which would promote public health awareness and ensure the quality of health services within the traditional practice. From this it can only be hoped that the role of indigenous healers will be better understood and appreciated.

- Based on the findings of the present study, it can be recommended that there is a need for a closer collaboration between indigenous healers and western trained practitioners such as medical doctors and mental health care givers such as psychologists, since the findings of this study indicated that an indigenous healer plays a role of a medical doctor and a psychologist within their communities.

- The current study focused on the conceptualisation of mental illness by VhaVenda indigenous healers. Given the findings of the study, the researcher recommends that studies should focus on the training or guidance that the indigenous healers believe they receive from their ancestors. Furthermore, such studies could also give consideration to the notion of mental illness prevention by indigenous healers.

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ANNEXURES

Annexure 1(a): Interview guide – English version

1. Would you like to share with me your understanding of mental illness?
2. I also would like you to explain the types of mental illnesses that you know of.
3. What do you perceive to be the signs and symptoms of mental illness?

Annexure 1(b): Interview guide – Tshivenda version

1. Ndi nga tama u ri vha nṱalutshedze nga vhuḓalo nga nḓila ine vha pfesesa u ri, vhulwadze ha muhumbulo ndi mini?
2. Ndi nga tama hafhu u ri vha nṱalutshedze nga ha dzi tshaka dzo fhambanaho dza vhulwadze ha muhumbulo dzi ne vha dzi divha.
3. Vha vhona u nga dzi tsumba dwadze dza vhulwadze ha muhumbulo ndi dzi fhio?

Annexure 2(a): Participant Consent Letter – English version

Department of Psychology

University of Limpopo (Turfloop Campus)

Private Bag X1106

Sovenga

0727

Date_____

Dear Participant

Thank you for showing interest in this study that focuses on the conceptualisation of mental illness by VhaVenda indigenous healers.

Your responses to the interview will remain strictly confidential. The researcher will attempt not to identify you with the responses you give during the interview or disclose your name as a participant in the study. Please note that your participation in this study is voluntary and you have the right to withdraw from participating at any time should you wish to do so.

Kindly answer all the questions as honestly as possible. Your participation in this study is very important. Thank you for your time and cooperation.

Kind regards

……………………   ……………………………

Sigida S.T.   Date

Masters Student

……………………   ……………………………

Prof. T. Sodi   Date

Supervisor

Annexure 2(b): Participant consent letter – Tshivenda version

Department of Psychology

University of Limpopo (Turfloop Campus)

Private Bag X1106

Sovenga

0727

Duvha:_____

Aa!

Ndi a livhuwa u sumbedzwa u takalela havho kha idzi ṱhoḓiso dza "Ku vhonele kwa dzi ṅanga dza Tshivenḓa nga ha vhulwadze ha muhumbulo".

Phindulo dzavho dza uvhu vhudavhidzani dzi ḓo vha tshiphirini. Muṱoḓisisi u ḓo lingedza u sa vhakwamanya na dzi phindulo dzavho kana u bvisela khagala dzina ḽavho sa mudzheneleli wa idzi ṱhoḓisiso. Vha ḓivhadzwa u ri u dzhenelela havho kha idzi ṱhoḓisiso ndi u voḽunthia, vha na thendelo ya u litsha tshifhinga tshiṅwe na tshiṅwe

Vha kho fhindula dzi mbudziso hedzi nga u fhulufhedzea, u dzhenelela havho kha idzi ṱhoḓisiso, ndi zwa ndeme kana vhuṱhogwa nga maanḓa. Ndi livhuwa tshifhinga tshavho na tshumisano ya vho.

Wavho

……………………   …………………………..

Sigida S.T.   Ḓuvha

Mutshudeni wa Masiṱasi

                                                     …………………………….

Prof.T. Sodi   Duvha

Mugudisi

71

Annexure 3(a): Consent form to be signed by the participant – English version

Consent form

I_____ hereby agree to participate in a master's research project that focuses on examining the conceptualisation of indigenous healers regarding mental illness.

The purpose of this study has been fully explained to me. Furthermore, I understand that I am participating freely and without being forced in any way to do so. I also understand that I can terminate my participation in this study at any point should I wish to do so and that this decision will not affect me negatively in any way.

I understand that this is a research project, whose purpose is not necessarily to benefit me personally. I understand that my details as they appear in this consent form will not be linked to the interview schedule and that my answers will remain confidential.

Signature: _____
Date: _____

Annexure 3(b): Consent form to be signed by the participant – Tshivenda version

Fomo ya thendelo

Nṋe _____ ndi a tenda u dzhenelela kha idzi ṱhodisiso dza masiṱasi, dza "Kuvhonele kwa ṅanga dza Tshivenḓa nga ha vhulwadze ha muhumbulo".

Ndo ṱalushedzwa nga vhuḓalo nga ha mushumo kana ndivho ya idzi ṱhoḓisiso. Ndi a pfesesa u ri ndi nga litsha u dzhenela kha idzi ṱhodisiso tshifhinga tshiṅwe na tshiṅwe arali ndi sa tsha zwi takalela na uri tsheo eyo i nga si ntsie ndi na masiandoitwa a si avhuḓi.

Ndi a pfesesa uri mushumo wa idzi ṱhoḓisiso a si u thusa nṋe, na u ri dzina ḽanga na mafhungo e nda amba zwi nga si bviselwe khagala.

Tsaino : _____

Ḓuvha : _____

Annexure 4: University of Limpopo Ethical clearance letter

University of Limpopo
Research Development and Administration Department
Private Bag X1106, Sovenga, 0727, South Africa
Tel: (015) 268 2212, Fax: (015) 268 2306, Email:noko.monene@ul.ac.za

TURFLOOP RESEARCH ETHICS COMMITTEE
CLEARANCE CERTIFICATE

MEETING: 05 March 2015

PROJECT NUMBER: TREC/18/2015: PG

PROJECT:

Title:	Conceptualisation of mental illness by Vhavenda Indigenous Healers
Researcher:	Ms ST Sigida
Supervisor:	Prof T Sodi
Co-Supervisor:	N/A
Department:	Psychology
School:	Social Science
Degree:	Masters in Psychology

PROF TAB MASHEGO
CHAIRPERSON: TURFLOOP RESEARCH ETHICS COMMITTEE

The Turfloop Research Ethics Committee (TREC) is registered with the National Health Research Ethics Council, Registration Number: **REC-0310111-031.**

Note:
i) Should any departure be contemplated from the research procedure as approved, the researcher(s) must re-submit the protocol to the committee.
ii) The budget for the research will be considered separately from the protocol.
PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES.

Finding solutions for Africa