A PHENOMENOLOGICAL STUDY OF THE PERCEPTIONS ON CHILDHOOD MENTAL ILLNESS BY NORTHERN SOTHO-SPEAKING ELDERLY PEOPLE IN MANKWENG COMMUNITY, LIMPOPO PROVINCE

By

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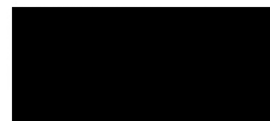
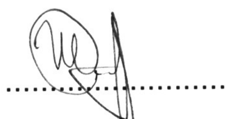
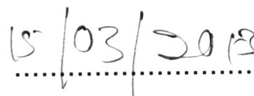


DECLARATION

I declare that **A PHENOMENOLOGICAL STUDY OF THE PERCEPTIONS ON CHILDHOOD MENTAL ILLNESS BY NORTHERN SOTHO-SPEAKING ELDERLY PEOPLE IN MANKWENG COMMUNITY, LIMPOPO PROVINCE** (mini-dissertation) hereby submitted to the University of Limpopo, for the degree of **MASTER OF ARTS, CLINICAL PSYCHOLOGY** has not previously been submitted by me for a degree at this or any other university; that it is my own work in design and in execution, and that all material contained herein has been duly acknowledged.





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Date

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ABSTRACT

The aim of the study was to explore the notions of childhood mental illness by Sepedi-speaking elderly people in the Mankweng community of Limpopo Province (South Africa). Using the phenomenological method, the researcher sought to understand these elderly people's notions with a view to: i) describing their conceptualizations of childhood mental illness; ii) determining their notions of the types and causes of mental illness; and iii) describing their views regarding the management of childhood mental illnesses. A total of 8 participants who were selected through snowball sampling were interviewed using unstructured interviews. The results of this study suggest that; i) childhood mental illness is better understood if described than defined, ii) childhood mental illness is manifested through behavioural and physical features, iii) there are many causal factors attributed to childhood mental illness, and iv) both Western and African traditional methods are recognized in the treatment of childhood mental illness in this rural community. The results are discussed in the context of the psychological literature on multicultural counseling and psychotherapy.

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CHAPTER ONE

INTRODUCTION

1.1 Introduction

According to Thompson (2007), the term mental illness refers to disorders in humans, which can profoundly disrupt a person's thinking, feelings, moods, ability to relate to others, and the capacity for coping with the demands of life. Much of the debate on culture and mental illness has made emphasis on the differences between cultures and systems of healing which exist across different cultures. However, the problems related to mental illness and its management facing mental health professionals across the globe are the same (Jacob, 1999). Mental illness remains a problem worldwide, with about 26.2 percent of Americans below age of 18 and older (about one in four adults), estimated to suffer from a diagnosable mental disorder in a given year (Kessler, Chiu, Demler & Walters, 2005).

From the argument made by the BME Mental Health Network (2012), culture plays a volatile role in the determination of the cause and reasoning around the issues of mental health. Different beliefs by different cultures can definitely shape the way in which people identify stress and the way they respond to it in seeking help. For example, in some cultures, people suffering from depression and anxiety disorders can also present with physical/psychosomatic symptoms.

Whilst the above conceptualization of mental illness, including the prevalence figures is based on Western norms for mental health and wellness, there are many studies that have suggested that notions of mental illness differ across cultures (Lewis-Fernandez & Diaz, 2002; Ngubane, 1977). In other words, what is defined as mental illness in one culture may not necessarily be seen as such

in another culture. In this regard, the DSM IV-TR has made provision for what is known as culture bound syndromes (APA, 2000). Such a step was taken because of the realization that the documented types of repetitive, patterned, and troubling sets of behaviour, experiences and observations may present themselves in the same way across cultures, but that these may carry different local names across those cultures. The considerations of culture-bound syndromes in the diagnostic manuals such as the DSM-IV-TR minimize chances of misdiagnosis, which may translate to ineffective treatment intervention due to the subjective and socially embedded conceptions of illnesses across cultures (Faulker, Faulker & Hesterberg, 2007).

Various experiences such as illness and healing across cultures are seen as phenomena that are socially constructed in accordance with their premises of cultural theories prevailing in those particular societies (Sodi, 1998). Perceptions about illness issues, such as diagnosis, etiological factors as well as the treatment methods sought are social constructs and thus, a reflection of societal values and norms (Castillo 1997; Ryder, Yang & Heini, 2002; Harkness & Keefer, 2000). Such factors make illness to be seen as a medical, social and cultural construct (Ngubane, 1977). Based on these studies, it is evident that there is a need for more studies to understand the cultural notions of mental illness in South Africa.

1.2 Background for the study

As briefly indicated earlier in this chapter, mental illness is a phenomenon that is culturally motivated. In most instances, according to the available literature and studies conducted, this is a concept that has developed more in the Western countries, which has then lead to the diffusion in terms of the way we understand this concept as South Africans. In different health facilities across the country, mental illness is understood with reference to the Western-based

literature which impacts on how it is handled. The use of manuals and coding systems, such as the Diagnostic and statistical manual of mental disorders, and International classification of mental disorders to better understand, define, classify, and treat mental illnesses.

Working in South Africa, with South African communities, poses a challenge in terms of bringing them to an understanding of what mental illness is. On the one hand, it is difficult for the communities to understand the concept of mental illness from the Western perspective, while on the other hand, the understanding of the concept from their own cultural point of view clashes with the Western perspective of the concept. The whole confusion brought an interest to the researcher. The researcher sought to explore Northern Sotho elderly community members' understanding of mental illness from their own culture. Furthermore, the researcher focused more on their understanding of mental illness in childhood, hence the title of this study.

The present study seeks to make a contribution in this regard by investigating subjective views of childhood mental illness by elderly people in one rural community in the Limpopo province.

1.3 Aim of the study

The aim of this study was to understand and describe the notions of childhood mental illness by northern Sotho-speaking elderly people in Mamotintane village (Mankweng area) of Limpopo Province.

1.4 Objectives of the study

The objectives of the study were:

- To understand and describe elderly people's conceptualizations of childhood mental illness;
- To explore these elderly people's notions of the types and causes of mental illness; and,
- To explore the elderly people's views regarding the management of childhood mental illness.

1.5 Main research questions

The study sought to answer the following research questions:

- How do elderly people conceptualize childhood mental illness?
- What are these elderly people's ideas regarding the types and causes of childhood mental illness?
- What are the elderly people's views regarding the management of childhood mental illness?

1.6 Definition of key concepts

- **Childhood** – This refers to that human stage of development which covers the individuals from birth until preadolescence, which is around thirteen years.
- **Mental illness –** is defined as disorders that can profoundly disrupt a person's thinking, feeling, moods, ability to relate to others, and the capacity for coping with the demands of life. It is diagnosed with the use

of standardized measures and criteria such as the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR) and others (Thompson, 2007).

- **Childhood mental illness** – is defined as a health problem among children that significantly affects how they feel, think, behave, and interact with other people, as well as how they generally function in a given environment with regard to the expectations of the surrounding society for their age (Looney, 1988).

- **Elderly** – for the purpose of this study, an elderly refers to any individual of the age of/or above 55 who is also receiving a pension grant.

- **Traditional healers** – In the context of this study, a traditional healer will be understood to mean any person who uses indigenous African methods of healing to restore good health to individuals and communities.

- **Western trained health professionals** – any health professional who is trained to use Western methods of treating and healing various diseases including mental illnesses. Such professional may include; psychologists, psychiatrists, neurologists and so on.

- **Aetiology/etiology** - The cause or origin of a disease, condition, or constellation of symptoms or signs, as determined by medical diagnosis or research (www.thefreedictionary.com, 2012).

- **Symptom** - a subjective manifestation of pathological condition. Symptoms are reported by the affected individual rather than observed the examiner (American Psychiatric Association, 2000).

- **Treatment** – (medical usage) the application of medicines, surgery, psychotherapy, etc., to a patient or to a disease or symptom (www.thefreedictionary.com, 2012).

1.7 Chapter outline

This study comprises of six chapters which are outlined as follows;

- In Chapter one, the background of the study including its aim and objectives were presented.
- Chapter two discusses the views from other relevant literature. Attention is devoted on both the Western and the African studies on the conceptualization, causations and management of mental illness. Culture bound syndromes were also discussed as well as the theoretical framework for the present study being the psychosocial perspectives.
- In chapter three, the methodology is discussed, with reference to the design, being the phenomenological research. Inclusive in this discussion is the sampling procedure, description of the research area, data collection, data analysis steps, and observed ethical issues.
- Chapter four discusses the participants' narratives of their experiences and understanding of the research concept. The researcher presented the narratives and extracted the themes and analysed them using interpretative phenomenological analysis. An analysis of how the themes related to each other is done so as to create new meanings of the participants' experiences.
- Chapter five discusses the findings of the study discussed in chapter four in line with the supporting literature and the theoretical framework for the study.
- Chapter six presents the conclusions made in the present study and further discusses the limitations and successes of the whole research process of the current study. Lastly, the recommendations for future studies are outlined.

1.8 Conclusion

The present chapter aimed at describing the outline of the study with reference to the background, the aim and objectives, and how the study could be significant to the community. Furthermore, the operational terms used in this study were defined, and lastly, the outline of the other remaining chapters was given. This chapter illustrates the roadmap that this present study will follow.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introductions

In this section, I will focus on the various perspectives on mental illness in various contexts, with the special reference to international perspectives, the South African perspective, culture-bound syndromes, theoretical perspectives on childhood mental illness, and lastly, the theoretical framework for the present study, which is the biopsychosocial perspective.

2.2 International perspectives on mental illness

Many studies conducted both internationally and locally have suggested that there are two popular ways in which the self can be understood. According to Sodi (1998), Western societies have a referential view of the self, which perceives an individual as an autonomous, independent and separate entity responsible for his/her behaviour. This conceptualization of the self has been found to be different from the indexical notion of the self which is believed to be common in African and other non-Western cultures (Shweder and Bourne, cited in Sodi, 1998). According to Shweder and Bourne, unlike the referential self which is a bounded and autonomous entity, the indexical self is perceived to have "loose" and "permeable" boundaries. These conceptualizations of the self are believed to lead to various conceptions about behavior and illness in different societies. For example, in societies that have a referential view of the self, mental illness and other forms of psychological dysfunctions are most likely to be attributed to what goes on inside the individual whilst those having an indexical view of the self are likely to see an individual's mental illness as a consequence of external environmental forces.

Several studies have been done to understand the conception of mental illness from an African point of view. For example a study by Jegede (2005) investigating the conception of mental illness by the Yoruba ethnic people of Nigeria, found that mental illness is a result of a number of causes that include natural sources (such as those resulting from accidents), supernatural or mystical sources (such as those resulting from the anger of the gods, and those caused by witchcraft) and inheritable ones. In the context of Yoruba culture, departure from approved ways of behavior, especially those on the extremes, is considered to be mental illness which is often known labelled as *"were"*.

According to Zondo (2008) illness according to an indigenous African perspective is complex and multifaceted. It includes such minor entities as religion, spirituality and kinship, biological and socio-ecological influences. Such conception is based on African ideologies of the self as a relational self. It is supported by the African saying "I am because we are" or "*umuntu ngumuntu ngabantu*," which suggests that our behavior is influenced by both the living and the spiritual beings in the form of ancestors and God. This philosophy plays an important role in terms of how indigenous African people will view, experience, and interprets life. Another important aspect about lay theories of illness causation is the 'supernatural world' which includes such entities as gods, spirits and ancestral spirits (Helman, 1990). Such entities are seen by people in the developing countries as luck, fate, and chance by modern developed world people.

According to Idemudia (2004), the conception of mental illness is subject to cultural differences. Harkness and Keefer (2000) argued that health and or illness are culturally defined and treated, since cultural meaning systems inform aspects of illness and some diseases are culturally specific. Africa is a multicultural continent, but the different cultures share the same meaning of the causal factors of both physical and mental diseases by largely attributing these

illness behavior as a consequence of: breach of a taboo or customs; disturbances in social relations; hostile ancestral spirits; spirit possession; demoniacal possession; evil machination and intrusion of objects; evil eye, sorcery; natural causes; and, affliction by God or gods.

A study conducted by Furnsham, Akande and Baguma (1999) which was aimed at investigating the beliefs about health and illness in three countries; Britain, South Africa and Uganda, found that the lay people are likely to blame their illnesses on witchcraft, sorcery and the 'evil eye', whereas conflict with spouses, children, family, friends, employees or workmates are factors that are most likely to be blamed as the causes of illness in the industrialised world.

According to Samouilhan and Seabi (2010), studies conducted in the industrialized world tend to attribute mental illness to genetics and chemical imbalances, in the case of schizophrenia, while life stressors and personal weaknesses are perceived as causal factors in depression. Similar trends have also been found in South Africa (Hugo, Boschoff, Traut, Zungu-Dirwayi & Stein, 2003). In the case of anorexia nervosa, many respondents in various studies reported that social factors such as the media and peer influences were responsible for the etiology of the illness. In one study conducted in Novosibirsk, Bratislava & Germany, it was established that a large proportion of the public perceived mental illnesses as a result of punishment by God for wrongdoing that they had committed. In African cultures, religion and spiritual beliefs inform behaviours and practices (Mbiti, 1990).

In Malaysia, there is recognition of culture-bound syndrome known as *amok* or *mata elap*. This refers to a dissociative episode characterized by a period of brooding which is followed by a sudden outburst of violence, aggression, of homicidal behaviour. Such behaviour is usually directed at people, non-human

objects, and animals. It is usually triggered by a slight perceived insult and it is more prevalent among males than females. The episode is often accompanied by persecutory ideas, automatism, amnesia about the episode period, exhaustion and, a return to the premorbid state following the episode. Such condition can either occur during a brief psychotic episode or constitute the onset, or exacerbate a chronic psychotic episode. This condition is similar to *cafard* or *cathard* (Polynesia), *mal de pelea* (Puerto Rico), *iich'aa* (Navaho), and syndromes found in Laos, Papua New Guinea, and the Philippines (Hall, 2008).

A study was conducted by Adewuya and Makanjuola to evaluate the pattern and correlates of lay beliefs regarding the causes of mental illness in south-Western Nigeria. This study was designed to be a cross-sectional survey in which respondents (n = 2,078) were administered a questionnaire detailing socio-demographic variables and perceived causation of mental illness. From this study, it was found that most people believed in supernatural factors and the misuse of psychoactive substances as etiological factors of mental illness. While urban dwelling, higher education status and familiarity with mental illness correlated with belief in biological and psychosocial causation, elderly rural dwellers and those who lacked familiarity with mental illness responded more in line with supernatural factors as causing mental illness. Educational status had no much effect in terms of the beliefs in supernatural causations (Adewuya & Makanjuola, 2008).

According to Mulemi (2009), indigenous illness aetiologies in Western Kenya typify African ideas and myths about the sources and origins of illness as manifestations of misfortunes in human experience. Disease and illness aetiologies are mostly associated with multiplicity of human, superhuman, and naturalistic factors. From this point of view, recognition is given to human causes of mental illness, natural and hereditary factors, misfortunes associated with God and spirits, and those syndromes which are associated with breach of

taboos and customs. When the indigenous people attribute illnesses to spiritual causes, they always explain the origin in terms of displeasure of ancestral spirits or God.

According to Franklin, Sarr, Gueye, Silla and Collignon (1996), mental illness in Senegal is viewed as manifesting from one of four invisible agents: witchcraft, sorcery, and attack by ancestral spirits or attacks by genies. Witches are thought to physically resemble ordinary people but to have certain innate and compelling supernatural powers that make them attack others and devour certain internal organs. Sorcery, or magic, in Senegal is believed to be different from witchcraft. It is thought to be produced by ordinary human beings who have learned to cast spells by undergoing long apprenticeships under magicians or through developing their own contacts in the spirit world. Since communications between the visible and invisible worlds are difficult, ancestral spirits are thought to produce madness in humans in attempt to have their presence recognized and ultimately have their wishes granted. Lastly, according to the local Islamic belief in Senegal, genies were created by God at the same time when he created man, and have the potential for doing either good or evil but with more intentions towards evil. Genies are believed to prefer living with their genie families in rural areas, often inhabiting particular trees and rock formations. Madness usually arises from genies, especially in the cases in which individuals accidentally stumble upon them. Senegalese thus associates madness of sudden onset, which occurs during a walk through an unfamiliar countryside to be caused by the powers of genies.

From the parapsychological point of view, as stated by Jacobsson (2002), induction of mental illness or psychosomatic disorders can occur as a result of a malicious wish or intention of somebody who wants to harm another person for a variety of reasons. Such people may consult a practitioner of witchcraft and sorcery, usually called *Tonquai*. This person then prepares a drug through the

use of various plants, which is given to the victim in his food and which will cause him to go mad or resulting in somatic problems. Other ways may include spearing the shadow of the victim or touching him or her in a special place, for example, on the shoulders. Another widespread concept is that of an evil eye in which others are thought of as bringing harm to others by looking at them.

2.3 South African cultural perspectives on mental illness

Several studies in South Africa have identified conditions that could be considered to be culture specific. These, among others include: *amafufunyana, and ukufa kwabantu*which are outlined below.

- ***Amafufunyana (mafofonyane***) is a type of mental state where an individual is believed to be possessed by spirits and will manifest symptoms such as mental derangement, hysteria, weeping uncontrollably, throwing oneself on the ground, tearing off clothing, and suicidal attempts (Ngubane, 1977). The spirits may speak through the sufferer in a similar way to how possessions and speaking in tongues is described in Pentecostal churches,

- ***Ukufa Kwabantu*** refers to culture-bound syndromes that are only prevalent in African societies, which are believed to originate from sorcery and as a result it is generally assumed that Western doctors cannot understand or treat them (Ngubane, 1977).

- ***Umkhuhlane:*** In the South African context, *umkhuhlane* refers to conditions that are considered to have natural causes. Some of the conditions identified include: the process of aging, mental retardation, genetic disorders, epilepsy, and schizophrenia among others.

2.4 Theoretical perspectives on childhood mental illness

2.4.1 The Psychodynamic Perspective

According to the psychodynamic theories, mental illness is a result of unconscious and unresolved conflicts in the person's mind. As stated by Freud, these conflicts arise in early childhood and may result in mental illness by interrupting the balanced development of the three systems that constitute the human psyche. These include; the id, which comprises innate sexual and aggressive drives; the ego, the conscious portion of the mind that mediates between the unconscious and reality; and the superego, which controls the primitive impulses of the id and represents moral ideals (Feist & Feist, 2006).

According to Butcher, Mineka and Hooley (2007), the id is the first to develop, being the source of instinctual drives. It operates on the pleasure principle. Secondly, the ego is the second structure to emerge, being the mediator of the demands of the id and the realities of the external world. The superego, the third one to develop, is the outgrowth of internalizing the taboos and moral values of society concerning what is right and wrong. Freud believed that the interplay of id, ego and superego is of crucial importance in determining behavior. Often, inner mental conflicts arise because the three subsystems are striving for different goals. If unresolved, these intrapsychic conflicts leads to mental disorder.

In this regard, generalized anxiety disorder, as one example, stem from a signal of unconscious danger or threat whose source can only be identified through an analysis of the person's personality and life experiences. One of the theories in this regard is Sigmund Freud's psychoanalytic theory which, for example, conceptualizes generalized anxiety disorder, among others, as a result of unresolved, unconscious conflicts between the three intra-psychic elements mentioned above (Saddock & Saddock, 2007).

2.4.2 The Behavioural Perspective

The behavioural perspective, championed by B.F. Skinner, maintains that psychology should confine itself to studying behaviour which is observable than exploring a person's unconscious feelings. In terms of this perspective, mental illness, as well as all of human behaviour, is a learned response to external stimuli. A person's behaviour is drastically shaped by rewards and punishment in the environment in which s/he finds oneself. A person generalizes due to the experience of rewards and punishments, which is responsible in causing mental illness (Skinner, 1979; Feist & Feist, 2006). Such theories include; Albert Bandura's social cognitive theory, Rotter and Mischel's cognitive social learning theory and Kelly's psychology of personal constructs among others. In line with these theories, one of the mental illnesses conceptualized in here is depression. Each person set goals for himself which, when reached, makes him feels as an achiever and become self actualized, but contrary to this, makes him depressed, lack of purposefulness, and pervasive, which goes along with aggression in children (Bandura, 1997).

2.4.3 The Humanistic / Existential Perspective

According to Carl Rogers, one of the pioneers of the humanistic existential perspective, every person has a drive towards self-actualization. Mental illness develops when circumstances in a person's environment block this drive

(Rogers, 1980). Along the same lines of argument, the existential perspective considers emotional disturbances as a result of an individual's failure to act authentically; meaning, to behave accordingly with one's own goals and values, rather than those of others (Watson, 2010). In the humanistic terms, according to Erik Fromm, another type of pathology named **incestuous symbiosis,** especially seen in childhood, and continues in adulthood is an extreme dependence on the mother or the mother surrogate, or simply a mother fixation. This is regarded as extreme and it is not founded on any sexual desire, and causes one to be depressed and anxious if he or she does not receive the attention of the mother or the mother figure (Feist & Feist, 2006).

2.4.4 The Socio-cultural Perspective

According to Aschenbrenner and Hellwig (2009) the sociocultural perspective associates mental illness with social, economic, and cultural factors as causal factors. In this perspective, most people suffering from mental illness are living in poverty, and unemployment. The shift in the world population from rural areas to cities, resulting in problems like overcrowding, noise, pollution, urban decay and social isolation has been implicated in the high rates of mental illness. Other factors like the abandonment of the indigenous ways of life and social disasters like warfare, genocide and violence have been found to lead to a higher risk of mental illness, especially depression, anxiety, and post-traumatic stress disorder.

2.4.5 Biological Perspective

From the biological perspective, most of mental disorders are associated with an imbalance in chemicals in the brain called neurotransmitters. There are many types of neurotransmitters; some increase the likelihood that the postsynaptic neuron will produce an impulse while others inhibit the impulse. In this instance, for example, dopamine has been implicated in schizophrenia and

addictive disorders. Serotonin increase and decrease has also been found to play a role in emotional disorders such as anxiety and depression as well as suicide (Butcher, Mineka & Hooley, 2007). These chemicals have a purpose of enhancing communication between the nerve cells of the brain. If these chemicals are out of balance or are not working properly, messages may not make it through the brain correctly, leading to symptoms of mental illness. Defects in or injury to certain areas of the brain have also been linked to some mental conditions (Chakraburtty, 2009).

Other factors include:

- **Genetics (Heredity)** – many mental illnesses have been found out to be running in families, suggesting that people who have family members with mental illness are more likely to develop mental illness even in the coming generations. Such susceptibility is made possible by genes. Experts believe that many mental illnesses are linked to abnormalities in many genes -- not just one (Chakraburtty, 2009). Other conditions such as such **myxedema**, are due to hormonal deficiencies that can be corrected by replacement therapy (Barondes, 1990)

- **Infections** – there are infections which are linked to brain damage and the development of mental illness or the worsening of its symptoms, such as a condition known as paediatric autoimmune neuropsychiatric disorder (PANDA), associated with the **Streptococcus** bacteria which has been linked to the development of obsessive-compulsive disorder and other mental illnesses in children (Chakraburtty, 2009).

- **Brain defects or injury** – defects in other parts of the brain are associated with the causation or maintenance of certain mental illnesses (Chakraburtty, 2009)

- **Prenatal damage** – research suggested that a disruption of early foetal brain development or trauma that occurs at the time of birth, such as loss of oxygen to the brain may be a factor in the development of certain conditions, such as autistic disorders in children (Chakraburtty, 2009).

- **Substance abuse** - long-term substance abuse, in particular, has been linked to anxiety, depression, and paranoia (Chakraburtty, 2009).

- **Other factors** – there are other factors such as poor nutrition - like **pellagra**, exposure to toxins, such as lead, which have been evidenced as playing a role in the development or maintenance of mental illness (Chakraburtty, 2009; Barondes, 1990).

2.4.6 Poverty and mental illness

According to Sebunnya, Kigozi, Lund, Kizza and Okello (2009), there has always been a relationship between poverty, stigma and mental illness, especially in the middle and upper income countries. This stigma is not only limited to those who are diagnosed with serious mental illness, but also their families over generations, institutions that provide treatment, psychotropic drugs and mental health workers (Satorius, 2007). While there is considerable descriptive evidence regarding the role of stigma in mental illness, there is also a large body of evidence from high, middle and low-income countries, demonstrating an association between poverty and mental illness. The

assumption is that poverty is not a resultant of mental illness, but a precedent of mental illnesses such as depression and anxiety, which makes it an important risk factor for mental illness and other negative outcomes (Saraceno & Barbui, 1997; Saraceno, Levav & Kohn, 2005; Patel & Kleinman, 2003).

According to Patel and Kleinman (2003), there is a considerable body of evidence from industrialized countries to demonstrate a relationship between poverty and risk for common mental disorders such as the common ones as depressive and anxiety disorders that are classified in ICD-10 (ICD-10, WHO, 1992) as "neurotic, stress-related and somatoform disorders" and "mood disorders". From an epidemiological perspective, poverty means low socioeconomic status (measured by social or income class), unemployment and low levels of education (Saraceno & Barbui, 1997). Patel and Kleinman conducted a study aimed to review the evidence from developing countries and explore the processes that may explain the poverty–risk relationship. From their findings, it was discussed that the relationship between poverty and mental illness is universal. Despite poverty causing mental illness, reverse causality was indicated; that mental illness in itself may cause disability and increased healthcare costs.

Sebunnya, Kigozi, Lund, Kizza and Okello conducted a study to get the opinions of a range of mental health stakeholders regarding poverty, stigma, mental illness and their relationship in the Ugandan context. This study formed part of a wider study which was aimed at exploring policy interventions required to address the vicious cycle of mental ill-health and poverty. They used semi-structured interviews and focus group discussions with various mental health stakeholders from various sectors. According to a range of mental health stakeholders in Uganda, there is a strong interrelationship between poverty, stigma and mental illness. These findings poses the need to recognize material resources as a central element in the fight against stigma of mental illness, and

the importance of stigma reduction programmes in protecting the mentally ill from social isolation, particularly in conditions of poverty (Sebunnya, Kigozi, Lund, Kizza & Okello, 2009).

2.5 Theoretical framework for the present study: The Biopsychosocial Perspective

In conceptualising and conducting this study, the researcher is guided by the biopsychosocial perspective which was developed by Adolph Meyer (Dombeck & Moran, 2006). This author postulates that mental health problems are hardly ever limited to just one domain of human experience (say, just a "mental" problem). Instead, most mental health problems are influenced by multiple domains of human experience, and have biological (medical), psychological (mental) and social/spiritual impacts (Dombeck & Moran, 2006).

The original view of this theory was that mental illness was a reaction of personality to biological, psychological as well as social factors. The basic assumptions of the biopsychosocial model were later outlined by Michael Wilson as follows: (i) the boundary between the mentally well and the mentally ill is fluid because normal persons can become ill if exposed to severe enough trauma; (ii) mental illness is conceived along a continuum of severity – from neurosis to borderline conditions to psychosis; (iii) the untoward mixture of noxious environment and psychic conflict causes mental illness; and, (iv) the mechanisms by which mental illness emerges in the individual are psychologically mediated (known as the principle of psychogenesis (Wilson, 1993). When using this model to assess children, a clinician should integrate all the information obtained into a formulation that takes into account the biological predisposition, psychodynamic factors, environmental stressors, and life events that have led to the child's level of functioning. Even in childhood mental illnesses, such as mental retardation, this model takes into consideration the

interplay of various factors in the child's immediate environment that can interfere with the child's functioning (Saddock & Saddock, 2007).

2.6 Conclusion

The present chapter sought to review various perspectives on how mental illness is viewed. Special reference was made to the Western perspectives on mental illness in contrast with African perspectives. It can be noted that mental illness is blamed on external and societal factors in the African belief system while in contrary; it is blamed on the chemical, biological and genetic factors in the Western belief system.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

In this section, a brief description of the research design is presented. This will be followed by a presentation of the research setting and the sampling method that was used to get the participants for the study. Data collection, data analysis and the ethical considerations are also discussed.

3.2. Research design

In this study, a qualitative research design was used. According to Creswell (1998) qualitative methodology is an inquiry process which is based on distinctive methodological approaches that seek to explore a social or human problem. Qualitative research is often credited for its ability to effectively obtain culturally specific information about the values, opinions, behaviours, and social contexts of particular populations (Mack, Woodsong, MacQuessn, Guest & Namey, 2005). In the present study, the phenomenological method of inquiry is used. According to Eatough and Smith (2008), phenomenology is concerned with the way things appear to us in experience. In other words, the reality that we live is an experiential one that is experienced through practical engagements with things and other individuals in the world, thus making it inherently meaningful. In phenomenological research, the researcher develops an understanding of a subject's or subjects' "reality" however he, she, or they so perceive. In essence, this approach investigates an individual's or group's perception of reality as he or she constructs it. These realities may be expressed as an event, program, relationship, emotion, and so on (Leedy, 1997).

The term "phenomenology" was first coined by the Swiss-German mathematician and philosopher Johann Heinrich Lambert in 1764 from two Greek words whose combined meaning was "the setting forth or articulation of what shows itself". He used this term in his reference to illusory nature of human experience in an attempt to develop a theory of knowledge that distinguished truth from error. This concept was furthered by Immanuel Kant, a contemporary of Lambert, who used the term twice, laying the foundation for its development "when he distinguished things as they appear to us (which he called phenomena) from things as they really are (which he called noumena)" (Moreau, 2001). Another scholar who used the word phenomenology was Georg W. F. Hegel in his *Phenomenology of the Spirit* published in 1807. Reacting against Kant's splitting of phenomena into *noumena* and phenomena he argued that instead of a split of phenomena of Kant, "phenomena were actual stages of knowledge progressing in evolutionary fashion from raw consciousness to absolute knowledge" (Moreau, 2001; Ekeke & Ekeopara, 2010). Later on, scientists like Edmund Husserl and Alfred Schutz preached the gospel further in advocating for the scientific nature of phenomenology. They carried it from the 19th century into the 20th century, then later on, into the 21st century as we find it now.

3.3. The setting: Mamotintane village

This study was conducted in Mamotintane village, in Ga-Mamabolo area which falls under ward 31 of the Polokwane municipality. The village is located approximately 30 kilometres east of Polokwane city, approximately 1 kilometre north of the University of Limpopo, Turfloop campus. The village is about 7 to 8 hectares in size, with about 300 households, accommodating a total population of about 4830 people (Mampa, Matladi, Malangeni & Leshilo, 2009).

The village is under the leadership of the Chief, Mr MP Mamabolo with Mr. MJ Mathosa serving as a Headman. The community is comprised mainly of

Northern Sotho speaking people with a significantly low number of the inhabitants speaking Xitsonga language. Most of the inhabitants are peasant farmers, with a few others employed in the neighbouring university as labourers (Mampa, Matladi, Malangeni & Leshilo, 2009).

3.4 Sampling

In this study, the elderly, in their rural setting were considered. According to Posey (2002), the elderly, or indigenous communities are those who, having their historical continuity, with pre-invasion and pre-colonial societies that have developed in their territories, consider themselves, and are also considered distinct from other sectors of their societies now emerging in those territories or parts of them (Posey, 2002). The elderly are thus viewed as sources of indigenous knowledge, and are playing a role of transmitting that information from one generation to the other so that it may not go distinct. The elderly are respected for their sound traditional knowledge of useful wild plants, animals and many others (De-Santayana, Tardio, Blanco, Carvalho, Lastra, Miguel & Morales, 2007). The researcher had chosen a sample of the elderly from a village setting because they still retain the traditional knowledge which is not saturated with the modern way of life, and who still make reference to their cultural way of doing things in order to solve their everyday situations.

For the purpose of this study, the sample of eight (08) elderly participants was selected through purposive and snowball sampling from the local village of Mamotintane in Mankweng. Purposive sampling is a sampling method which targets a particular group of people. When the desired population for the study is rare or very difficult to locate and recruit for a study, purposive sampling may be the convenient option. It is a viable method of accessing a particular subset of people, the elderly in the case of this study. The people who do not fit a particular profile are excluded (Trochim, 2006). This method is based on the

researcher's judgment regarding the characteristics of a representative sample which is chosen on the basis of what the researcher considers to be typical units. The strategy is to choose units that are judged to be the most common in the population under investigation (Bless, Higson-Smith & Kagee, 2006). According to Bajpai (2010) snowball sampling refers to a sampling method in which research participants or survey respondents are selected on the basis of referrals from other respondents. Respondents assist in providing researchers with the selection of other respondents whose profiles will fit the study. It is a method which is used by researchers to locate appropriate participants for their study.

In the present study, one elderly person known to the researcher was approached and recruited to participate in the study. This elderly person was then asked to identify other elderly people that she knows who were also approached and requested to participate in the study. This sampling process was continued until a total number of eight participants were secured. The difficulty arose when other elderly individuals chose not to participate in the study. Respecting the involuntary nature of the study, force was never used and all the participants who participated only did that out of their voluntary will.

3.5 Data collection

According to Herman and Bentley (1993), an unstructured interview is a spontaneous conversation, not a specific set of questions asked in a predetermined order. This type of interview helps in gathering much information from the participants without limiting them, and also in giving the researcher an opportunity to follow the emerging areas of interest from the participants' responses. It may also assist the researcher in following up the questions or statements which were not anticipated before the study through its lack of the structure.

In the present study, semi structured interviews were conducted. The interviews were conducted in northern Sotho which is the language spoken in the area. The interviews were conducted in the privacy of the participants' homes in the village of Mamotintanes. The interviews were audio taped to ensure that data is accurately captured.

3.6 Data analysis

3.6.1 Interpretative phenomenological analysis

For the purpose of this study, interpretative phenomenological analysis was used. The interpretative phenomenological analysis was first developed by Jonathan Smith. This approach's theoretical foundations stems from the phenomenological approach which originated with Hussel's attempts to construct a philosophical science of consciousness, with hermeneutics: (the theory of interpretation), and symbolic-interactionism. Symbolic interactionism posits that the meanings an individual ascribes to events are of central concern but are only accessible through an interpretative process (Biggerstaff & Thompson, 2008). IPA is today used widely in psychology in many different countries. IPA acknowledges that the researcher's engagement with the participant's text has an interpretative element, yet in contrast to some other qualitative data analysis methods, it assumes an epistemological stance whereby, through careful and explicit interpretative methodology, it becomes possible to access an individual's cognitive inner world (Biggerstaff & Thompson, 2008).

3.6.2 IPA data analysis steps

The audiotaped protocols derived from the unstructured interviews were transcribed before they were translated into English. The translated protocols were then analysed by using interpretative phenomenological analysis (IPA)

steps discussed below. According to Eatough & Smith (2008), interpretative phenomenological analysis concerns itself with the detailed examination of the individual lived experiences and how individuals make sense out of those experiences. The following steps as suggested by Eatough & Smith (2008) were followed:

Step One: Managing the information collected

In this step, the researcher aimed to organize the data into categorical clusters such as files or folders for convenience in analysis. The researcher organized the data through the use of a computer into representative names/concepts, sentences and paragraphs for convenience in analysing and final writing.

Step Two: Memoing

Following in this step was the process of reading the protocols for several times by the researcher as a way of familiarizing himself with them before dismantling them into parts. Common concepts were identified from the protocols.

Step Three: Describing, classifying and interpreting

This process was followed in which the researcher was aimed at noting the commonalities in the transcripts of the data collected from the participants, categorizing the information into relevant divisions of categories or common themes. He went further in making sense out of the data in such a way that concepts, categories and themes can better be described and explained in a good presentation.

The researcher derived meaning out of the clustered categories, themes and concepts of the data, and united and indicated a link between the data derived from transcripts. By so doing, the researcher indicated the commonalities and differences in ideas that were arising from the participants' transcripts.

Step Four: Representation and visualization

This final step involves formulating the data for the final writing of results in a presentable manner, usually in a text form.

In this final step, the researcher presented in a written format, the themes and subthemes that emerged from the study such that he was categorizing them into the main aims of the study, namely; the description of childhood mental illness, different types, symptom picture, causal factors, and lastly, the treatment methods. The themes and subthemes were presented as reported by the participants.

3.7 Discussion and conclusion

The discussion of the results of this study will be presented in chapter five while the conclusion will therefore be presented in the sixth and last chapter.

3.8 Ethical considerations

The following ethical principles were observed by the researcher during the research process:

3.8.1 Informed consent

Research participants have a right to know what the research is about, how it will affect them, the risks and benefits of participation, and the fact that they have the right to decline to participate if they choose to do so (Bless *et al,* 2006). In this regard, the researcher explained the purpose of the study to the participants and advised them about their right to choose whether or not to participate (see Appendix C).

Five participants in the study only consented verbally and refused to bind themselves in writing, which the researcher respected. Three of the participants gave a written consent for their participation in the study.

3.8.2 Permission to conduct the study

The researcher received a written approval by the university research ethics committee before he commenced with the study.

3.8.3 Anonymity and confidentiality

Confidentiality and anonymity are the ethical requirements in research. Sensitive and personal information provided by participants should not be made available to everyone (Bless *et al,* 2006).

The researcher gave assurance to the participants about their real names not being used during this study, and that their identity will not be revealed.

3.8.4 Respect for participants' rights and dignity

The researcher observed throughout the research process, the basic principle relating to participants' rights and dignity. Cultural values were also observed and respected.

3.9 Conclusion

The aim of the researcher in this chapter was to discuss the methodology of the study with special reference to the design, being the phenomenological research. The sampling process was also discussed. The setting in which the study was conducted was also outlined. Lastly, the data collection methods, data analysis steps and ethical issues were discussed.

CHAPTER FOUR

RESULTS

4.1. Introduction

In the first part of the chapter, the demographic characteristics of the participants are presented. In the second part, the themes emerging from the phenomenological explication of the interview protocols are presented. In this regard, the following psychological themes were identified by the present study: a). Childhood mental illness is better understood if described than defined; b). Childhood mental illness is manifested through behavioural and physical features; c). There are many causal factors attributed to childhood mental illness; and, d). Both Western and African traditional methods are recognized in the treatment of childhood mental illness. The chapter is concluded by giving a summary of the findings from the present study.

4.2. Demographic characteristics of the participants

As already indicated in the previous chapter, the sample for this study consisted of 8 participants (female = 7; male = 1; aged between 55 and 70) who were drawn from Mamotintane village (Table 1). All the 8 participants were northern Sotho speaking people of African descent. The homogeneity of the participants in this study could be attributable to the fact that Mamotintane village has been predominantly inhabited by this language group in terms of the geo-political history of South Africa. Amongst the participants, one female was a traditional healer (Participant 3). Another participant demonstrated a good understanding of cultural healing practices because she grew up closer to her grandfather who was a traditional healer (Participant 8).

Table 1: Demographic characteristics of the participants

Participant No:	Age	Gender	Language
Participant 1	55	Female	Sepedi
Participant 2	58	Female	Sepedi
Participant 3 (traditional healer)	70	Female	Sepedi
Participant 4	62	Female	Sepedi
Participant 5	66	Male	Sepedi
Participant 6	66	Female	Sepedi
Participant 7	58	Female	Sepedi
Participant 8	59	Female	Sepedi

4.3. Phenomenological explication

4.3.1. Childhood mental illness is better understood if described than defined

Childhood mental illness as understood by the participants in this study does seem difficult to define. Instead, the participants tended to give a description of what childhood mental illness is whenever they were asked to comment as to what it is. The following extracts illustrate this point:

> *"Yes, childhood mental illness is there. You may find that the child, when you speak to him, he just looks at you without replying. Then, when he holds something, he can't .And you find that when he is seated, he salivates. He can't do a thing. He is hard at hearing, and he answers irrelevantly".* (Participant 7)*:*

> *"One can explain by saying we observe that one child is different from others. Yes. That is the children's mental illness. You see it by the difference between children. Things he does may not be understood, sometimes he is too slow. We send him maybe to*

fetch water. Those with a mental illness when you send them to bring you water you will be surprised when they may not know what water is". (Participant 4)

(Participant 2)*: "...........Ok, the little I understand in these childhood mental illnesses. Those are illnesses wherein the child does not seem to be clever. Yes! You realize him while still young when he can't play with other kids".*

"You find that you have a child, still a baby; this child is less intelligent than his counterparts. Also, when you breast feed the baby you cuddle him, he doesn't play, and he is not doing things of his time. He is just surprising. And when you look at his face, to inspect his eyes, he becomes slow." (Participant 8)

4.3.2. Childhood mental illness is manifested through behavioural and physical features

The results of this study suggest that childhood mental illness is manifested through behavioural and physical features.

4.3.2.1. Behavioural features: The children with childhood mental illness were reported to show behaviour that is awkward. For example, they may throw important things all over, such as food and utensils. The following extracts illustrate this point:

"........even when you bathe them they are not agreeable with anything? When you call him to bathe he may start crying, or pick up everything and throws them away. That proves that he is not normal. Even his actions one may realize that he doesn't do things like other children do. Even with toys he doesn't handle them like others. ." (Participant 1)

Other participants reported that children with mental illness withdraw themselves from other children and engage in solitary activities:

> *"He will not even play with other children; instead he will prefer to play alone".* (Participant 1)

> *"...........as I have already explained, some cannot play well with others, some are so withdrawn that they can't even play."* (Participant 2)

> *"Mostly he is not someone who is keen to play with others. Even when he is old at about eight years he doesn't want to be with other people. He likes being alone. From there, they prefer being with their parents alone at home when he is tired."* (Participant 5)

Children with mental illness also show some speech problems and articulation difficulties as reflected in the following extracts:

> *"When you try to talk to him, talking to him about things he understands. He must be this size, (measures by her hand). Then you speak to him like this. Then others are able to speak. But you realize that this person is not normal."* (Participant 3)

> (Participant 5) *"You find that when you speak to him you realize that he does not speak like people who are normal."*

Children with mental illness were also reported to be slow in doing things when compared to children without the illness.

> *"Sometimes he is too slow. Yes. As if his mind is not like those of other kids. That is, let me say, I will quote an English word. He is not 'active'."* (Participant 4)

One participant reported that children with mental illness often display anger outbursts, often over trivial things. Such children easily lose their temper when reprimanded. Consequently they may leave their homes and will not return until their relatives go out looking for them.

> *"..........a mentally ill child sometimes when you speak to him at home he might just get angry. Yes, he is unlike other children. Even when you try to warn him reprimanding him for a minor thing, to him it's a great thing as he will be forcing what he wants. Sometimes he just goes out and leaves you. Ultimately we go out into the village to look for him with the help of the community."* (Participant 6)

It was also reported that, due to the mental illness, such children are often unable to differentiate between edible and inedible objects or things. They may eat inedible objects such as their faeces. They may also defecate and play with their own faeces.

> *"Usually when they are still young they pick up inedible things on the floor. ....then, at times he relieves himself and then eats his faeces."* (Participant 3)

In some cases, children with mental illness are unable to show the same level of understanding of instructions when compared to children without mental illness. As one participant put it:

> *"............we send him (child with mental illness) maybe to fetch water. Those with a mental illness when you send them to bring you water you will be surprised when they may not know what water is."* (Participant 5)

Children with childhood mental illness often wet themselves. They also sometimes struggle to understand when spoken to.

> *"He might while eating, hold the utensil in his mouth for a while, when you give him water, he bites the calabash. He bites it for some time. Ultimately he is wet with the water, as if he was asleep, and he has just woken up. After urinating, he gains consciousness, then, on waking up, he is no more himself. He is confused."* (Participant 8)

4.3.2.2. Physical features: Most of the participants in this study reported that there were observable physical features that differentiate children with mental illness from the normal children. As one of the participants put it:

> *"This child, it starts from the hands to the legs. As you look you will realize that his joints are not well aligned. ..... Even if you try to carry him up, his body is palsied, it's not strong."* (Participant 3)

According to some participants, children with mental illness differ from other children by their looks on their faces and eyes.

> (Participant 2) *"When you look into his face you see that he is bored,......even his eyes are not just ok, I don't know how to explain it, but just by mere looking in his face you realize that the child has a problem."*
>
> *"He is just surprising. And when you look at his face, to inspect his eyes, he becomes slow."* (Participant 8)

4.3.3. There are many causal factors attributed to childhood mental illness

4.3.3.1. Hereditary/Biological factors: Hereditary and biological factors were reported by some participants as causes of childhood mental illnesses. A child with such illnesses might have inherited the condition from previous generations, such as great grandparents, grandparents or immediate parents.

> *"There are those illnesses where the child is born incomplete mentally, and they sometimes say, it's hereditary. Meaning, he inherited it from one of his parents' family. He took after someone; great grandfather, or great grandmother."* (Participant 1)

> *"Actually, these illnesses may be hereditary. You find that his granny the mother to, or his great grandfather maybe somewhere in the past. That is, it depends on geneology. The illness is in the genes. Like when someone is mad. You find that this family, starting from long ago, there had been someone with a similar illness in the family. Then it is inherited from generation to generation. You find that every one of your children has such a child."* (Participant 7)

> *"At times, there might have been some relative, or in your husband's family, Who has had this illness in the past? It then comes and surface through the child. Then the elders recall that someone once had a child like this one."* (Participant 8)

4.3.3.2. Witchcraft: This was reported as one of the common factors leading to childhood mental illness as reflected in the following extracts:

> *"You find that, with other children, its witchcraft, and bewitchment. You find that people are after your child and you find the child in that state in which he is; mentally ill."* (Participant 6)

(Participant 7) *"Sometimes, childhood mental illness is caused by the African magic; witchcraft."*

"Again, sometimes, the cause of childhood mental illness can be witchcraft. It depends on whether you believe it." (Participant 8)

4.3.3.3. Prenatal complications and maternal stress: Among the factors identified by the participants, prenatal complications and stressful situations during pregnancy may result in mental illness in the newborn baby.

"The cause of the children's mental illness in my opinion, sometimes I can say but I am not sure about food, the mother's stress. Some people have more stress when they are pregnant. And sometimes there are conflicts in the family. The child's mother may be over stressed; I think it may pass on to the child's mind." (Participant 4)

Domestic violence was described as one of the possible causes of maternal stress as reflected in the following extract:

"Sometimes, maybe, the parent had problems while still pregnant. Sometimes you are bullied by the husband and you simply stomach it? You can't go and report anywhere. You just stand it when the husband beats you, and doing all sorts of things, torturing you. Too much stress when you are pregnant, affect even the foetus. Then, he will come out somehow affected. Yes. It's going to affect the foetus. Because she was much under stress while pregnant. Actually a pregnant person must not be tortured. She must relax, that is, have a stable state of the mind." (Participant 7)

4.3.3.4. Maternal substance use during pregnancy: The use of substances by mothers during pregnancy was perceived by some participants as a critical cause of childhood mental illness. According to the participants who expressed this view, substances such as alcohol and tobacco have a negative impact on the mental functioning of the baby if exposed to them while still in the womb.

> *"The other thing may be alcohol. We sometimes hear that pregnant person should not take alcohol. And they must also not smoke while pregnant. When those things reach her, they are going to affect the child's mind."* (Participant 4)

> *"Alright, Yes, the way I have seen it with young parents, they give birth while still young themselves. Mostly what I have seen is that these children use drugs while still young, drugs like benzene. They, what do they call it, alcohol, and these ones that are smoked. When the child is born, you can easily see he has a problem. Just there he will be mentally weak to prove that he has a mental illness. My understanding is that those drugs they smoke while pregnant have an effect on the child. As a parent that thing drugs you. The child is mentally damaged even before he is born."* (Participant 2)

4.3.3.5. Taboos and contravention of prohibited acts: Doing what is culturally prohibited by the society is believed by some participants to lead to childhood mental illness.

> *"I don't know the truth. Others say in our culture that it is when you sleep around."* (Participant 3)

> *"In my thinking maybe, they might be caused by these things called family planning, these tablets… when someone is about to conceive, they conceives by choice. They don't conceive like in the past. Then you will realize that it is because of what they use*

from the Westerners, in the hospitals where they use them. Those things are causing trouble for them. It is better, instead of contraception, to declare that I totally do not want a child, not through contraception. Then they can simply cut off the womb and that's it. Then when they give birth their children are not normal." (Participant 5)

"... you must respect taboos the way you are told, like when they say as you are pregnant you must behave in such and such a manner. Like when they say you must not go and watch these types of animals. Like baboons and monkeys which you must not watch." (Participant 8)

"Today people have TVs and you find someone looking at puppets. Not all those puppets depict acceptable actions. They play in very quire ways and the little baby in the womb is going to play in the same way, the ones the mother watched, she was enjoying them, seated and laughing. At the same time the baby is also growing, when it is born it will play just like those puppets." (Participant 1)

4.3.3.6. Evil spirits: One participant attributed childhood mental illness to evil spirits.

"Then, secondly I will use that biblical word 'evil spirits' or 'demons'. People are able to pass you evil spirits while pregnant. The child starts by getting mixed up and then goes confused." (Participant 4)

4.3.3.7. Punishment by God: In line with a view that fertility control causes childhood mental illness, one participant reported that these actions are foreign

in the African culture. Consequently, such prohibited actions lead to the parents being punished by God.

> *"……… conceives by choice. They don't conceive like in the past. They do it by choice. Then God punishes them."* (Participant 5)

4.3.4. Both Western and African traditional methods are recognized in the treatment of childhood mental illness

From the results of this study, it does appear that both Western and African traditional methods of healing are recognized in the treatment of childhood mental illness.

4.3.4.1. Western healing methods: A number of participants were of the view that children with mental illness should receive treatment from hospitals and clinics where doctors prescribe Western medicines and tablets for the management of such illnesses.

> *"In trying to help such children we take them to the doctors in hospital, they will know how to assist just to improve the situation so that the child must not come and make noise in the house, or just doing silly things. They are the ones who help and they are the only ones I know."* (Participant 1)

> *"……., mostly when a child has a mental illness, what I usually see people doing is only to take them to hospital. That's all. I have never seen any other thing that people did to cure the illness. I can't say you can cure it because to tell the truth people get sick for ever. So in other words I think it is incurable."* (Participant 2)

> *"Using those tablets, they are able to help them improve. But you may easily see them even after having taken the tablets; one can see that they are not normal. I don't think that with a mental illness we have a cure."* (Participant 5)

One participant even went further to discourage the use of African traditional methods in the treatment of childhood mental illness as these were perceived as less humane.

> *"……with me, the only help for these mentally ill children should be taken to hospitals for check-ups, and get tablets. I can't see any good practice in a traditional treatment because they don't treat them nicely."* (Participant 4)

4.3.4.2. African traditional healing methods: Some other participants in this study reported that childhood mental illnesses can best be treated using African traditional healing methods. Among others, such traditional methods include bathing the patient with traditional medicines, cleansing through oral medicines, inhalation of medicines, and steam bath that is prepared with a concoction of medicinal items.

> *"Truly if it is natural from the past, the hereditary one, those old men and women who knew how to use herbs, they had cures which they administered and people recovered. They knew that if we had treated the child this way, he may spend a certain number of years without the illness."* (Participant 6)

> *"…..in our culture if you take him to the healers, even though I don't know what they use but they are able to diagnose, and allow him to sniff some herbs, and give him their medicine. They do as they can, and you find that as you take him for checkups, it is possible for him to recover from the cultural healers."* (Participant7)

Participant 3, who was also a traditional healer, gave an elaborate explanation of different methods of administering the treatment to children with mental illness.

> *"The mentally ill child one is cured through herbs. You let him take it and you inject him several times. When you realise that he is no more taking them, his mind is becoming normal. Then you start giving him medicine to drink only. You do that to normalise the mind and to clean their stomach. If you give him something to vomit, you also steam him. Then we are going to bring the medicine here* **(pointing at her head)***, then the other one he just smokes like cigarette. When you smoke like us who smoke through the nostrils, when you smoke then it comes directly to the head? Let's say he is like us who take snuff, as you sniff you feel that you are now ok "*(Participant 3)

Participant 3 (the traditional healer) went on to give details on some of the ingredients that are included in the medicines that are used to treat childhood mental illness.

> *"Do you know Mohlono (a wild apricot tree)? Then you take its roots and pound them, and then you steam it in water and also sneeze the smoke to reduce the blood, Understand?"* (Participant 3)

One other participant also gave her own experiences of treating childhood mental illness. She explained that she acquired this experience from her grandfather who was a traditional healer. Interestingly, this particular participant did not regard herself as a traditional healer even though she believed she had some skills to treat childhood mental illness. She explained that she developed medicines by mixing different herbs and soaking them in water. They were then

removed and poured in a '*Leselo*', (a traditional reed tray) and poured on top of the mentally ill child on the road intersections. This was done in the morning. The water in which the herbs were soaked was then used as a medicine which was taken orally. In her own words;

> *"Nowadays, people rush to the doctors. That's why I am saying those old healers, knew that they were going to take the plants like, wild fig 'mokgoba' (dikbasboom), acacia, and mix them together. Then they take 'dithete' (the earth worms), as the falling child usually bites themselves, not so? They mix them all in a pot. Then they knew that in the morning, they take that child and put him in the intersection of a pathway, and pour the mixture on him, to alleviate him of the effect of the contact as such. Then he takes a week taking the mixture orally. Yes, so that he must recover. "(*Participant 8)

> *"They soak them in water. They put them in water and soak them. Then the following day they pour them on him using 'leselo' (a traditional reed tray), at an intersection. They pour them and put the 'leselo' upside down there. Then later in the day, they go back and turn it correctly. That's the way to cure that illness. They take that water, and pour it on him. They use all of it. Some remain in the pot, for him to drink thereafter, the one that was given to him like medicine."* (Participant 8)

4.4. Summary of findings

From the results of this study a number of themes emerged. These are: i) childhood mental illness is better understood if described than defined, ii) childhood mental illness is manifested through behavioural and physical features, iii) there are many causal factors attributed to childhood mental illness,

and iv) both Western and African traditional methods are recognized in the treatment of childhood mental illness in this rural community.

CHAPTER FIVE

DISCUSSION

5.1 Introduction

This present chapter aims at discussing the results of this study that were presented in the previous chapter. It starts by giving an outline of the biopsychosocial model of mental illness as a way of explaining these results. It moves further to discuss the themes presented in the previous chapter, with reference to the description of mental illness, manifestation, causal factors and the treatment modalities through integrating them with the relevant literature.

5.2 The 'bio-psychosocial' perspective on mental illness

As previously discussed in chapter 2, the biopsychosocial perspective attributes mental illness to the interplay of biological (medical), psychological (mental) and social (relational) factors. This perspective was developed by Adolph Meyer (Dombeck & Moran, 2006). In support of the results of this study, the biopsychosocial perspective acknowledges the biological factors as contributing positively to the conception of mental illness. As reflected in the results section, it does appear that the elderly people in this rural community understand genetic and hereditary factors to have a role to play in the causation of childhood mental illness. Social or relational factors such as conflicts with spouses and other social members may result into maternal psychological instability. On the other hand, the mother's psychological negativity may result into stress and other prenatal complications that in turn may result in the causation of childhood mental illness. Witchcraft was also found to be a possible cause of mental illness.

5.3 Phenomenological explications

5.3.1 Description of childhood mental illness

Most participants in this study found it easier to describe rather than to define childhood mental illness. In the view of most participants, childhood mental illness is understood more as a social construct that cannot easily be defined.

5.3.2 Manifestations of childhood mental illness

Results of this study suggest that childhood mental illness manifest itself in terms of behavioural or physical features. This finding seems to be consistent with the view by Sadock and Sadock (2003) who pointed out that mental illness is a manifestation of a behavioural, psychological or biological dysfunction in the individual.

In the present study, the behavioural features that were described by the participants included: a child withdrawing, throwing things all over the place, speech, being too slow when engaging in activities, unfounded anger outbursts, inability to differentiate between edible and inedible things, inability to understand and follow instructions when spoken to, and wetting themselves. This finding is consistent with what Schuchman and McDonald (2004) found to be the case among children in Somalia.

It was reported in the results of this study that children with childhood mental illness display some features which differentiate them from other children. These features include; facial looks and the looks in their eyes. The Canadian Mental Health Association supports these findings by arguing that mental illness is characterized by physical and observable symptoms. Children exhibit many symptoms that are typically dismissed as attitude problems or evidence of low

intelligence. With observation many of these symptoms are clues to more serious but treatable conditions. Studies show that 6 to 11% of children have diagnosable mental disorders (Canadian Mental Health Association, 2006).

5.3.3 Causal factors for childhood mental illness

The results of this study suggested that there are many factors which can be seen as causes of childhood mental illness.

5.3.3.1 Hereditary and genetic factors

In the present study, some hereditary factors were found to cause childhood mental illness. This is consistent with the study by Samouilhan & Seabi (2010) which suggested that in most industrialized countries childhood mental illness is attributable to genetics and chemical imbalances. This view is also shared by Chakraburtty (2009) who argued that many mental illnesses have been found out to be running in families.

5.3.3.2 Supernatural Factors

In the present study, witchcraft was found to be one of the factors associated with childhood mental illnesses. This is consistent with the results of a number of previous studies that have sought to investigate the causes of mental illness in the African continent. For example, in his study that focused on the Yoruba people in Nigeria (Jegede, 2005) found that mental illness is perceived as emanating from supernatural or mystical sources such as anger by the gods and witchcraft. This was also endorsed by Loveday (2001), Harkness and Keefer (2000) and Franklin, Sarr, Gueye, Silla and Collignon (1996) who argued that in terms of the African worldview, the idea that mental illness (like all other illnesses) is caused by witchcraft among others. In a study that was conducted in three countries (namely; Britain, South Africa and Uganda) to investigate

people's beliefs about health and illness, it was also found that African lay people tend to blame their illnesses on witchcraft, sorcery and the 'evil eye' (Furnsham, Akande & Baguma, 1999).

5.3.3.3 Taboos and contravention of prohibited acts

Some participants in the present study attributed childhood mental illness to contraventions by parents of taboos and prohibited acts. This finding is consistent with the results of a previous study by Mulemi (2009) who found that misfortunes in some communities in Kenya are associated with breach of taboos and customs.

5.3.3.4 Prenatal complications and maternal stress

The results of this study also suggest that there is a role played by stress and maternal complications during pregnancy. As reported by the participants, maternal stress may be a result of domestic violence. According to Dipietro (2002) maternal prenatal stress, or anxiety play a contributory role in childhood mental illness.

5.3.3.5 Maternal substance use during pregnancy

Some of the participants in the present study were of the view that substances such as alcohol and tobacco are very dangerous toxins for the unborn child. The suggestion is that these substances do play a role in causing childhood mental illness. In Nigeria the available literature is not conclusive on the beliefs of the community about the causes of mental illness. While mystical causes were most frequently reported in central Nigeria (Akighir, 1982), misuse of drugs was the most widely held belief regarding causation of mental illness in

northern Nigeria (Adewuya & Makanjuola, 2008; Kabir, Iliyasu, Abubakar, & Aliyu, 2004).

5.3.3.6 Evil spirits

The present study also found that some participants were of the view that childhood mental illness could be caused by 'evil spirits'. A recent study conducted in the Yoruba communities in the south Western pole of Nigeria suggested that evil spirits were among the other factors that were attributed to mental illness (Adewuya & Makanjuola, 2008.

5.3.4 The role played by both Western and African traditional methods in treating childhood mental illness

Most participants were of the view that both Western and traditional methods of healing have a role to play in the treatment of childhood mental illnesses.

5.3.4.1 Western-based treatment methods

Some participants suggested that children with mental illness should only be taken to the hospital to be seen by Western trained health practitioners. In these settings, Western-based medicines and tablets are useful and prescribed in the treatment of such illnesses. According to Sadock and Sadock the treatment for both children and adults suffering from various sorts of mental illness can be sought in medical and psychiatric facilities from psychiatrists and doctors (Sadock & Sadock, 2003; 2007).

5.3.4.2 African traditional treatment methods

Some of the participants in the present study were of the view that African traditional methods are useful in the treatment of mental illness. Some of the specific methods of treatment mentioned include: inhalation of medicines, cleansing through the use of oral medicines, using oral mixtures of herbs, bathing the patient with traditional medicines, and steam bathing through the use of concoctions of traditional medicinal items. The study conducted by Sorsdahl, Flisher, Wilson and Stein (2010) acknowledges the role of traditional healers in the treatment of mental illnesses suggesting that in many traditional belief systems in Africa, including South Africa, mental health problems may be attributed to the influence of ancestors or to bewitchment. In such contexts, traditional healers are viewed as having the expertise to address these causes.. In an earlier study in Uganda, Ovuga, Boardman & Oluka (1999) found that traditional healers used a number of healing methods in the treatment of childhood mental illness. These included: therapeutic cuts to the head and body in order to administer herbs, herbal nasal drops or sniffing herbal medicine, the use of oral herbal medicine, bathing, or washing with herbal water and inhalation of burning herbs.

5.4 Conclusion

This chapter was aimed at discussing the results of this study presented in chapter four. Highlighted in this chapter was the theoretical framework of this study and to integrate it with the findings of this study. Furthermore, the themes presented in the previous chapter were further discussed with the use of the supporting literature. Lastly, as part of the themes, the Western and African treatment practices were discussed. South Africa shares the same sentiments in treating mental illness with other countries in the African continent.

CHAPTER SIX

CONCLUSION

6.1 A brief summary of findings

The purpose of this study was to explore the conceptualization of childhood mental illness by the elderly in their indigenous African setting. The first objective of this study was to explore the elderly's understanding of what childhood mental illness is. From the findings, it was easier for the participants to provide a description other than a clear definition of the concept under investigation. From their own experiences, mental illness was observable through the behavioural output and the physical and facial features. These factors are of paramount importance in helping differentiate mentally ill children from those without mental illness. In contrast, it was concluded that in the Western context, childhood mental illness can be defined while in the African indigenous context, it is better described than defined. This was supported by the literature consulted.

The second objective of the present study was to understand the participants' perceptions about the types and causes of childhood mental illness. From the participant's point of view, such illnesses were categorized into either the illnesses of the mountain resembling the behaviours of mountain animals such as monkeys. Another category is that of what they referred to as the falling sickness. From the researcher's understanding, what was described as the falling sickness by the participants resembled what is known as epilepsy from the Western perspective. In the area involving the causes of childhood mental illnesses the participants named factors including; witchcraft, taboos and contravention of prohibited acts, prenatal complications and maternal stress, maternal substance use during pregnancy, evil spirits, God's punishment, and genetic/hereditary factors among others. This study concurred with the

Western-oriented perceptions about hereditary factors causing childhood mental illness. This study also agreed with most of the African-oriented studies focusing on the other causal factors as contributory to childhood mental illness.

The third objective of the study was to understand and describe African indigenous methods of treating childhood mental illness. Two treatment modalities were reported by the participants. Some participants supported the Western-oriented treatment methods which involve the use of Western-based medicine and tablets, prescribed by psychiatrists, psychiatric nurses and psychologists among others. On the other hand, some participants demonstrated their support for the African traditional ways of treatment, emphasizing on the procedures that include among others; inhalation of burning herbs, steam bathing through the use of concoctions of traditional medicinal items, bathing with traditional medicines, cleansing, and the use of oral mixture of herbs. The reported treatment methods and the procedures followed carry a significant meaning that makes sense to the people using and believing in them. This is the reason such factors as specified areas, specified times, and specified medicinal items are strictly adhered to due to the symbolic meaning they carry.

6.2 Theoretical framework for this study

From the findings of this study, especially in the causal factors to be precise, an indication has been made about the interplay of many factors as contributing to childhood mental illness. Social factors such as witchcraft, hereditary or biological factors, as well as psychological factors have been indicated as causal to childhood mental illness. The results share the same sentiments with the theoretical framework for this study; the biopsychosocial perspective. This idea suggests that there has never been any deviation from the theoretical perspective of this study. Lastly, this suggests that with regard to this perspective and the results of this study, there is a thin line that differentiates

the African belief system from the Western belief system in accordance with the application of this theoretical framework.

6.3 Significance of the study

This study was viewed in the light of helping mental health professionals to better understand the notions of childhood mental illness as perceived by elderly people in a South African rural context. It is hoped that the results of this study could thus make a contribution towards efforts aimed at promoting multicultural counselling and psychotherapy. It achieved its purpose by bringing awareness to the mental health practitioners as to how mental illness is generally perceived in the South African context. This awareness may guide such practises to a higher level. It will also contribute to the patients' freedom and choice of treatment between the Western and African contexts.

This study also gave acknowledgement to the existence and importance of indigenous healing practices. This, as a result concurs with the sole purpose of the newly developed Indigenous Knowledge System (IKS) to promoting traditional healers and their practice in as far as mental illness is concerned. By so doing, this retains the African traditional healing practices.

The results of this study could make a contribution to the growing body of knowledge in critical fields like indigenous psychology, African psychology and cross-cultural psychology. They also have the potential to benefit South Africa and other developing communities in documenting indigenous knowledge on childhood mental illness.

6.4 Limitations of the study

Apart from the successes of this study, there are some limitations which should be equally considered. Most of the participants in this study (that is, seven out of eight) were female. The bias towards female participants could have denied the researcher the opportunity to get a balanced gender view of childhood mental illness in this community.

Secondly, the sample that was used in this study was small. This makes it difficult to generalise the findings of this study to a larger population. It is also important to note that the research findings were only limited to the Mamotintane village, and should be treated as such.

6.5 Recommendations for future studies

However, there are certain issues that were raised from this study, that form the basis for further investigation. Based on the results of the present study, the following recommendations are made for future studies;

- Future studies should seek to have gender balance in terms of the participants so that the views of both males and females regarding childhood mental illness can be canvassed.
- The sample size in this present study was small, which contributed to some of the issues such as the types of childhood mental illness yielding little information. In future studies, a bigger sample size should be considered in order to address such issues.
- The views of traditional healers regarding the causes and treatment of mental illness should be sought. This could help in deepening our understanding of the cultural notions of mental illness in the rural communities.

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APPENDICES

APPENDIX A: INTERVIEW GUIDE

- How do you define and describe childhood mental illness?
- Can you share with me your ideas regarding the types and manifestations of childhood mental illness?
- Can you share with me your views regarding the causes of childhood mental illness?
- Can you share with me your views regarding the management of childhood mental illness?

APPENDIX B: DIPOTŠIŠO TŠA NYAKIŠIŠO

- Naa le kwišiša bjang, gape le ka hlaloša bjang malwetši a bana a monagano?
- Aa le ka nnyetlela kwišišo ya lena mabapi le mehuta le mokgwa wa tšwelelo ya malwetši a bana a monagano?
- As le ka nnyetlela kwišišo ya lena mabapi le seo se hlolago malwetši ao a bana a monagano?
- Aa le ka nnyetlela kwišišo ya lena mabapi le ka mokgwa woo malwetši ao a bana a monagano a ka laolwago ka gona?

APPENDIX C: PARTICIPANT CONSENT LETTER AND FORM

Department of Psychology
University of Limpopo (Turfloop Campus)
Private Bag X1106
Sovenga
0727
Date________________________

Dear Participant

Thank you for showing interest in participating in this study that looks at the perceptions about childhood mental illnesses by the elderly in the Mamotintane village of the Mankweng community. The purpose of this study is mainly to understand the elderly people's perceptions about childhood mental illnesses in the Mamotintane village.

Your responses to this individual unstructured interview will be treated as highly confidential, and the researcher will treat your identity and name as confidential and will not in anyway disclose them with the results of this study. Please be informed that participation in this study is voluntary, and you thus have the right to terminate the continuations of the interview at any time.

Kindly answer all the questions to the best of your ability; hence, your participation in this study is very important. Thank you for you time.

Sincerely

______________________ ______________________

Jones Makgabo Date
Masters Student

______________________ ______________________

Prof. Sodi Date
Supervisor

APPENDIX D: LETLAKALA LE FOROMO YA TUMELELANO YA BATŠEAKAROLO

Department of Psychology
University of Limpopo (Turfloop Campus)
Private Bag X1106
Sovenga
0727
Date_______________________

Motšeakarolo yo a hlomphegago

Ke leboga go bontšha kgahlego ga gago ka go tšea karolo mo nyakišišong ye yeo e lebelelanego le go kwišiša dikgopolo tša batho ba bagolo (batšofadi) mabapi le malwetši a bana a monagano mo motseselegaeng wa Mamotintane tikologong ya Mankweng. Maikemišetšo a nyakišišo ye ke go kwišiša dikgopolo tša batšofadi mabapi le malwetši a bana a monagano mo motseselegaeng wa Mamotintane.

Dikarabo tša gago mo poledišanong ya bobedi bja rena di tla swarwa bjalo ka sephiri, gape monyakišiši o tla swara boitsebišo le leina la gago bjalo ka sephiri gomme a ka se di tšweletše le dipoelo tša nyakišišo ye. O lemošwa gore botšeakarolo mo nyakišišong ye bo ka boithaopi, gomme o na le tokelo ya go emiša poledišano ya rena nako efe kapa efe.

O kgopelwa go araba dipotšišo go ya le ka moo o ka kgonago, ka ge botšeakarolo bja gago mo nyakišišong ye bo le bohlokwa. Ke leboga nako ya gago.

Ka boikokobetšo

________________________ ____________________

Jones Makgabo Date

Moithuti wa Masters

________________________ ____________________

Prof. Sodi Date

Mohlahli

APPENDIX E: CONCENT FORM TO BE SIGNED BY THE PARTICIPANT

CONCENT FORM

I____ hereby agree to participate in this research project which focuses on the elderly people's perceptions about childhood mental illnesses in the Mamotintane village of the Mankweng community.

The purpose, terms and conditions of the study have been thoroughly explained to me and I thus understand my rights and freedom in participating in this study. I also understand my freedom and the right I have to terminate the continuation of this study should I feel like discontinuing with my participation at any time.

I understand that the outcomes of this study will not benefit me personally, and I also understand that my identifying details provided in this form will not, in any way be linked to the results of this study. I understand that my name and my answers in this study will remain confidential.

Signature ____________________

Date ________________________

APPENDIX F: FOROMO YA TUMELELANO YEO E SAENAGO KE MOTŠEAKAROLO

FOROMO YA TUMELELANO

Nna ____ ke dumela go tšea karolo mo nyakišišong yeo o nyakišišago ka dikgopolo tša batšofadi mabapi le malwetši a bana a monagano mo motseselegaeng wa Mamotintane, tikologong ya Mankweng.

Maikemišetšo le mabaka ao a beilwego ka nyakišišo ye a hlalošitšwe ka botlalo gomme kea a kwešiša. Gape ke kwešiša le ditokelo le bolokologi bja ka mo botšeakarolong bja nyakišišo ye. Ke kwešiša gape le bolokologi le tokelo ya ka ya go emiša ka tšwelopele nyakišišong ye ge ke nyaka go emiša ka go tšea karolo nako efe kapa efe.

Ke a kwešiša gore dipoelo tša nyakišišo ye di ka se nkhole ka bonna, ke kwešiša gape le gore tshedimošo ya ka ya boitsebišo yeo e filwego foromong ye e ka se amantšhwe le dipoelo tša nyakišišo ye. Ke a kwešiša gore leina la ka le dikarabo tša ka di tla swarwa bjalo ka sephiri.

Signature ____________________

Date ________________________