AN EXPLORATION OF SHONA TRADITIONAL HEALERS' CONCEPTUALISATION AND TREATMENT OF MENTAL ILLNESS

By

PERCY TARUVINGA

A THESIS

Submitted in fulfilment of the requirements for the degree of

DOCTOR OF PHILOSOPHY

in

PSYCHOLOGY

in the

FACULTY OF HUMANITIES
(School of Social sciences)

at the

UNIVERSITY OF LIMPOPO
(Turfloop Campus)

SUPERVISOR: Prof. T. Sodi

2016

DEDICATION

This thesis is dedicated to my late mother Stella Zambezi. Even in death you still are called the doctor's mother (*Amai vadhokota*).

DECLARATION

I declare that **AN EXPLORATION OF SHONA TRADITIONAL HEALERS' CONCEPTUALISATION AND TREATMENT OF MENTAL ILLNESS** is my own work and all the sources I have used and quoted have been indicated and acknowledged by means of complete references and that this work has not been submitted before for any degree.

…… ……

Full names Date

ACKNOWLEDGEMENTS

- I want to thank my supervisor Professor T. Sodi for his dedicated supervision and objective comments throughout my studies.

- I also want to thank my wife Talent Taruvinga for her support and believing in me throughout my studies. Thank you for being so loving and understanding.

- To my only daughter, Esther Taruvinga, who has been my inspiration throughout the period of study.

- To my parents, Mr Mischeck Zambezi and the late Mrs Stella Zambezi, thank you for loving and encouraging me even when I did not believe I could do it.

- I am also grateful to the traditional healers who sacrificed their time to share experiences. Without them, this study would not have been possible.

- Last but not least, I would like to thank my siblings Mike, Sure, Linna, Faith, Jean and Cythia Chirinda for the support and motivation which they all gave me.

ABSTRACT

After the World Health Organization (WHO) declared 2010 a decade of indigenous knowledge systems, there has been an increase in the studies on the role of African traditional healers in describing mental illness and its treatment. Studies have pointed to the relevance of traditional healing in primary health care in many developing countries. The aim of the present study was to explore the conceptualisation and treatment of mental illness by Zezuru Shona traditional healers in Goromonzi District in Zimbabwe.

A qualitative research design, and in particular, the phenomenological method was used in the present study. Ten Shona traditional healers were selected through purposive and snowball sampling and requested to participate in the study. Data was collected through in-depth interviews and analysed using Hycner's phenomenological explicitation process. Five major themes related to the traiditonal healers' conceptualisation on mental illness were identified. These are: a). Types/characteristics of mental illness; b). Causes of mental illness; c). Diagnosis and treatment of mental illness; d). Challenges faced by traditional healers; and, e). Facilitating factors in the work of traditional healers. The study further revealed that there are a number of illnesses that are are not mental illness but could be closely associated with mental illness. These are epilepsy (*pfari*), locking (*kusungwa*) and sexual dysfunctions. Culture was found to play a central role in the traditional healers' conceptualisation and treatment of mental illness. In this regard, spirituality was found to be a critical factor in the work of traditional healers in diagnosing, interpreting, treating and preventing mental illness and the associated conditions of ill health. These results were discussed in the context of indigenous knowledge systems and mental illness. The study is concluded by recommending the need to have a holistic understanding of mental illness and associated conditions.

TABLE OF CONTENTS

Page

DEDICATION i
DECLARATION ii
ACKNOWLEDGEMENTS iii
ABSTRACT iv
TABLE OF CONTENTS v
GLOSSARY x
LIST OF TABLES xiv
LIST OF FIGURES xiv
CHAPTER I 1
INTRODUCTION AND BACKGROUND 1
1.1 Background to the study 1
1.2 Research problem 4
1.3 Significance of proposed research 5
1.4 Definitions of key concepts 5
1.5 Purpose of the study 6
1.5.1 Aim of the study 6
1.5.2 Objectives of the study 6
1.5.3 Research questions 6
1.6 Conclusion 7
CHAPTER 2 8
LITERATURE REVIEW 8
2.1 Introduction 8
2.2 Prevalence of mental illness in Zimbabwe 8
2.3 Culture and mental illness 9
2.3.1 Universality versus culture relativist views on mental illness 9
2.3.2 How culture affects psychiatric disorder 9
2.3.3 African traditional conceptualisations of mental illness 10
2.3.4 Traditional healing 11
2.3.5 Marginalization of traditional healers 12
2.4 Mental illness among Shona people 14

2.4.1 Types of mental illness 15
2.4.2 Perception of mental illness among Shona people 15
2.4.3 Causes of mental Illness 18
2.4.4 Dealing with mental illness in Shona society 20
2.4.5 Treatment of mental illness among Shona people 21
2.4.6 Mental illness and modernisation among Shona people 23
2.4.7 Diagnostic manuals and the spirit component of African tradition 24
2.5 Concluding remarks 25
CHAPTER 3 26
THEORETICAL PERSPECTIVES ON MENTAL ILLNESS 26
3.1 Introduction 26
3.2 Psychodynamic theory of mental illness 26
3.3 Cognitive-behavioural perspective on mental illness 29
3.4 Existential-humanistic perspective on mental illness 30
3.5 Theoretical framework: The Afrocentric perspective 30
3.6 Concluding remarks 31
CHAPTER 4 32
RESEARCH METHODOLOGY 32
4.1 Introduction 32
4.2 Research design 32
4.3 Study setting 33
4.4 Sampling 35
4.5 Participants' demographic information 37
4.6 Data collection 38
4.7 Data analysis 40
4.7.1 Bracketing and phenomenological reduction 40
4.7.2 Delineating units of meaning 41
4.7.3 Clustering of units of meaning to form themes 41
4.7.4 Summarising each interview, validation and modification 42
4.7.5 Extracting general and unique themes from all the interviews and making a composite summary 42
4.8 Quality criteria 42
4.8.1 Credibility 43
4.8.2 Transferability 44
4.8.3 Trustworthiness 45

4.9 Ethical considerations 45
4.9.1 Permission to conduct the study 45
4.9.2 Informed consent 46
4.9.3 Confidentiality/anonymity and privacy 46
4.9.4 Respect for persons 46
4.9.5 Debriefing of respondents 47
4.10 Concluding remarks 47
CHAPTER 5 48
FINDINGS OF THE STUDY 48
5.1 Introduction 48
PART A: EMERGING THEMES AND SUBTHEMES 48
5.2 Conceptualisation of mental illness by Shona speaking traditional healers 48
5.2.1 Theme 1: Types/characteristics of mental illness 50
5.2.2 Theme 2: Causes of mental illness 59
5.2.3 Theme 3: Diagnosis and treatment of mental illness 68
5.2.4 Theme 4: Challenges faced by traditional healers 79
5.2.5 Theme 5: Facilitating factors in the work of traditional healers 84
5.3 Conceptualisation of associated illnesses by Shona speaking traditional healers 87
5.3.1 Theme 1: Epilepsy (*Pfari*) 88
5.3.2 Theme 2: Sexual dysfunction (*Kusungwa*) 93
PART B: PSYCHOLOGICAL DESCRIPTION AND INTERPRETATION 102
5.4 Conceptualisation of mental illnesses 102
5.4.1 Psychotic features 103
5.4.2 Anxiety symptoms 104
5.5 Causes of mental illness 105
5.5.1 Internal factors 105
5.5.2 Cultural factors (External factors) 105
5.6 Diagnosis and treatment of mental illness 107
5.6.1 *Kushopera* (Divination) 107
5.6.2 *Girazi* (Looking glass) 107
5.6.3 *Kurotswa* (Use of dreams) 107
5.6.4 *Mushonga* (Medicine) 108
5.6.5 Treating evil spirits 108
5.7 Challenges faced by traditional healers 109
5.7.1 *Kutadza kushanda kwemushonga* (Treatment failure) 109

5.7.2 *Kutsamwa* (Anger) 110
5.7.3 *Kuba* (Theft of ideas and intellectual property rights) 110
5.7.4 *Rusarura* (Discrimination) 110
5.8 Facilitating factors in the work of traditional healers 110
5.8.1 *Kuvimbika* (Honesty) 111
5.8.2 *Kubhadhara kwakareruka* (Flexible payment arrangements) 111
5.8.3 *Kudzidzisana* (Continuous professional development) 111
5.9 Conceptualisation and treatment of associated illnesses 112
5.9.1 *Pfari* (Epilepsy) 112
5.9.2 *Kusungwa* (Sexual dysfunctions) 112
5.10 Causes of associated illnesses 114
5.10.1 Causes of *pfari* (Epilepsy) 114
5.10.2 *Causes of kusungwa* (Sexual dysfunctions) 115
5.11 Treatment of associated illnesses 116
5.11.1 Treatment of *pfari* (Epilepsy) 116
5.11.2 Treatment of kusungwa (sexual dysfunctions) 116
5.12 Concluding remarks 117
CHAPTER 6 118
DISCUSSION OF THE FINDINGS 118
6.1 Introduction 118
6.2 Conceptualisation of mental illness by Shona traditional healers 118
6.2.1 Characteristics of mental illness 118
6.2.2 Causes of mental illness 120
6.2.3 Diagnosis and treatment of mental illness 121
6.2.4 Challenges faced by traditional healers 125
6.2.5 Facilitating factors in the work of traditional healers 128
6.3 Conceptualisation and treatment of associated illnesses by traditional healers 130
6.3.1 Epilepsy (*Pfari*) 130
6.3.2 Sexual dysfunctions (*Kusungwa*) 133
6.4 Concluding remarks 135
CHAPTER 7 136
SUMMARY AND CONCLUSION 136
7.1 Introduction 136
7.2 Summary of research findings 136
7.2.1 Conceptualisation of mental illness 136

7.2.1.1 Characteristics/types of mental illness 136
7.2.1.2 Causes of mental illness 137
7.2.1.3 Diagnosis and treatment of mental illness 137
7.2.1.4 Challenges and facilitating factors in traditional healers' work 137
7.2.2 Conceptualisation of associated illnesses 138
7.2.2.1 *Pfari* (Epilepsy) 138
7.2.2.1.1 Characteristics of *pfari* (Epilepsy) 138
7.2.2.1.2 Causes of p*fari* (Epilepsy) 138
7.2.2.1.3 Treatment of *pfari* (Epilepsy) 139
7.2.2.2 Sexual dysfunctions (*Kusungwa*) 139
7.2.2.2.1 Characteristics of Sexual dysfunctions (*Kusungwa*) 139
7.2.2.2.2 Causes of Sexual dysfunctions (*Kusungwa*) 139
7.2.2.2.3 Treatment of Sexual dysfunctions (*Kusungwa*) 139
7.3 Implications of the findings 140
7.3.1 Implications for those who offer help to the mentally ill 140
7.3.2 Implication of the findings to the Afrocentric perspective 140
7.3.3 Implication of the findings for policy and programs 141
7.3.4 Implication of the findings for future research 141
7.4 Limitations of the study 141
References 143
ANNEXURES 169
Annexure 1a: Interview guide (English version) 169
Annexure 1b: Interview guide (Shona version) 169
Annexure 2a: Participant's consent letter and form (English version) 170
Annexure 2b: Participant's consent letter and form (Shona version) 171
Annexure 3a: Consent form to participate in a research study to be signed by the participant (English version) 172
Annexure 3b: Consent form to participate in a research study to be signed by the participant (Shona version) 173
Annexure 4: Ethical clerance certificate 174

GLOSSARY

Chirwere chemuri refers to illness which is passed from one generation to another, for example from parent to child.

Chivimbiso chekuti mushonga haikuvadze is the assurance given to ensure that the medicine is safe.

Datya is a frog which is used symbolically to cause mental illness.

Dzungu is a feeling of dizziness.

Girazi is a looking glass used in treatment of illness and is powered by ancestral spirit.

Godo is when an individual is envious of another person and wants to harm for individual due to evil intentions.

Hembe kana chipenga nemushonga is when a partner takes a thread or piece of underwear and mix it with medicine to cause sexual dysfunction.

Huroyi is the use of evil spirits with the intention to cause harm on another person.

Kamba is a tortoise.

Kuba refers to theft of either ideas or items.

Kubhadhara kusingaremere vanhu refers to payment of fees in a way which flexible.

Kubvisa mweya wakaipa refers to ways of dealing with evil spirits.

Kudhonza mhepo kuti itaure refers to the process of inducing a spirit which is possessing a client to say who it is and what it wants.

Kudya zvakaraswa is scavenging from bins so that one can eat.

Kudya zvisina mwero is bad eating habits.

Kudzidzisana refers to learning from the experience of each other.

Kudzokera mukati kwenhengo yemurume refers to a sudden involuntary withdrawal of an erect penis when the man tires to penetrate a woman in sexual intercourse.

Kudzosera mweya wakaipa kune awutumira is when a traditional healer redirects an evil spirit to afflict the sender or wrong doer.

Kufambwa fambwa refers to feeling as if something is crawling on an individual's skin or tactile perceptual disturbance.

Kufuratidzwa moyo refers to losing sexual interest by a male or female.

Kukanganwa hama dzepedyo refers to failure to recognise familiar close relatives.

Kunyararisa is when an individual suddenly becomes unresponsive to spoken words and become mute.

Kupindura nyoka yemudumbu refers to the use of spiritual powers to turn the oviducts in a way which infertility.

Kupunzika is falling or failing to maintain balance.

Kurohwa nehana refers to experiencing rapid uncontrolled heatbeat or increased/irregular heart beat.

Kurasika pakutaura is failing to maintain a specific line of thought.

Kuripa refers to compensation for a wrong which was commited.

Kurerutsa basa refers to enhancing treatment to overcome barriers.

Kuromba is the use of the spirit of the dead or magic charm by an evil person in orderto become rich.

Kurotomoka refers to illogical thoughts.

Kurotswa is the use of dreams in diagnosing or treating illness.

Kusagara pasi is when oneis wandering about for no reason.

Kusaitira mudzimu zvaunoda refers to failing to appease the ancestors by doing what they want or request.

Kusangana kweropa nehuropi refers to head trauma or the mixing of blood and brain material.

Kusaongororwa zvakanaka refers ro unfair assessments the traditional healing systems by authorities who are not well informed in the system.

Kusapihwawo varwere refers to one way referral system which does not show reciprocity between traditional healers and biomedical health care providers.

Kusazvishambidza refers to poor or compromised hygiene such as not bathing or washing clothes.

Kuseka zvakapfuura mwero is when individual laughs inappropriately.

Kusimikira refers to providing a fertility treatment using plant material.

Kushopera refers to the use of divination in diagnosing and treating illness.

Kusudurudza mhepo is a technique used by traditional healers to push away an evil spirit in order to restore sanity in an individual.

Kusungwa is preventing physical pleasure, sexual desire, arousal or orgasm.

Kusunungura refers to unlocking the sexual dysfunction using medicine which restores the sexual function.

Kutadza kumira kwenhengo yemurume refers failure in a man to experience an erection or to maintain it.

Kutadza kutunda is when a male fails to ejaculate following a successful erection and penetration.

Kutadza kushanda refers to inability to perform occupational responsibilities totally or partially.

Kutaura wega is when one is talking to self.

Kutemwa nemusoro refers to experiencing headache.

Kuteya is setting a spiritualtrap which causes mental illness.

Kutsamwa refers to a feeling of anger.

Kuuraya nhengo refers to intentionally seeking assistance sought from a traditional healer to diminish or stop libido being motivated by the need to become rich.

Kuvimbika refers to being honesty.

Mari yekuti makwenzi avhenekwe refers to the exorbitant costs for traditional healers to have their medicine tested.

Mupfuhwira refers to love portion which is in the form of plant and animal parts.

Mushonga refers to any medicine in the form of plant and animal material.

Mushonga unotadza kushanda refers to the failure of treatment to be effective.

Mushonga wekuchaisa refers to a cultural laxative.

Mweya yakaipa inotevera mudzimu is the evil spirit which follows the ancestral spirit.

Ndove yenzou refers to the dung of an elephant.

Ngozi refers to a spirit which has been wronged while living and is now avenging, examples *ngozi yaamai*- a mothers's avenging spirit and *ngozi yemutorwa*- a stranger's avenging spirit.

Njuzu yemukosvi is a parasite or a growth on a tree know as *mukosvi*.

Nzira dzekubata chirwere refers to the ways of making a diagnosis.

Nzira dzekurapa chirwere refers to ways of treating the illness.

Nzira dzekupa mushonga refers to ways of administering the medicine.

Pfari refers to epileptic fits where an individual falls, foams and experiences perceptual disturbances.

Rusarura refers to discrimination as authorities unfairly treat different systems.

Ruware refers to impenetrable vagina which is caused by spiritual manipulation by those with evil intentions.

Tsvubvu (hubvu or hubva) is a smelly-berry which turns black when ripe.

Zvikwambo/zvishiri refers to manipulation of animal like creatures in witchcraft to cause harm.

LIST OF TABLES

Table 1 Participants` demographic information 37

Table 2 Emerging themes and sub-themes in the conceptualisation and treatment of mental illness by Shona traditional healers 48

Table 3 Emerging themes and sub-themes in the conceptualisation and treatment of associated illnesses 87

LIST OF FIGURES

Figure 1 Map of Zimbabwe showing Goromonzi District……34

CHAPTER 1

INTRODUCTION AND BACKGROUND

1.1 Background to the study

In a study funded by the United States of America's National Institute of Mental Health (NIMH) and supported by the Global Alliance for Chronic Diseases (GACD), Collins, Patel, Joestl, March, Insel and Daar (2011) found that schizophrenia, depression, epilepsy, dementia, alcohol dependence and other mental, neurological and substance-use (MNS) disorders constitute 13% of the global burden of disease. These findings were in support of consecutive reports by the World Health Organisation (WHO) which has found that mental and neurological disorders are some of the leading causes of ill health and disability globally (WHO, 2005; 2006; 2011). In a recent report, titled World Health Statistics 2012, the World Health Organization (WHO), put the figure of mental health problems at an estimated 14% of all global health conditions (WHO, 2012). Despite these high levels of mental health problems, it was indicated in the same WHO report, that most countries globally spend less than 1% of their healthcare budgets on mental health.

WHO (2012) stated that, more than 450 million people in the world are perceived to be suffering from mental illness. This makes mental illness a serious global concern. WHO (2007) further estimated that about 40% of the people consulting at clinics in Sub-Saharian Africa have mental health problems. When looking at Zimbabwe, Refugee Review Tribunal Australia (2009) revealed that the number of people suffering from mental illness had been increasing due to the tough economic and social environment (one in every four people in Zimbabwe suffers from a mental disorder). All this coupled with severe shortage of resources at the country's second largest psychiatric institution, Ngomahuru Hospital in Masvingo according to the Zimbabwe National Association for Mental Health (ZIMNAMH) newsletter (2009), makes the treatment gap for mental illness to be more pounced. Saxena, Thornicroft, Knapp, and Whiteford (2007) concurs by stating that treatment gap for even the most severe mental disorders is large and is most pronounced in lower-income settings, of which Zimbabwe is one.

Studies have revealed that there is high need for mental services since more than 13% of the global burden of disease is due to neuropsychiatric disorders. It is disturbing to note that almost three quarters of this burden lies in low- and middle-income countries (LMICs) (Lopez, Mathers, Ezzati, Jamison, & Murray, 2006). In order to deal with this burden, Llosa, Ghantous, Souza, Forgione, Bastin, Jones, Antierens, Slavuckij and Grais (2014) highlighted the importance of understanding mental health-related cultural beliefs and barriers to accessing available support. This was believed to improve the provision of appropriate, acceptable and effective care for the mentally ill.

Common mental disorders (CMD), have been found to be the leading causes of disease burden globally (WHO, 2004). In low and middle income countries (LMIC) such as Zimbabwe, literature suggests that CMD are poorly recognised and managed resulting in a large treatment gap (Prince, Patel, Saxena, Maj, Maselko, Phillips, & Rahman, 2007). Research has indicated a growing body of evidence suggesting that non-health cadres, such as (Lay health workers) LHWs, can work effectively in addressing issues including mental health (Chibanda, Mesu, Kajawu, Cowan, Araya, Abas, 2011). Collaborative care models that incorporate systematic identification of patients, active case management (Bower, Gilbody, Richards, Fletcher, Sutton, 2006) would reduce mental problems. The best solution in resolving this treatment gap in LMICs is to take advantage of the existing primary health care facilities (Walley, Lawn, Tinker, de Francisco, Chopra, et al., 2008).

Many low and middle-income countries (LMICs) have less than one psychiatrist per 100,000 population. In particular, there is a scarcity of professionals. This lack of human resources is a major contributor to a worldwide treatment gap for LMIC (Farooq, Large, Nielssen, Waheed, 2009). The World Health Organization (WHO) ATLAS (WHO, 2005) clearly shows that there is lack of adequate mental health services in many parts of the world, especially in rural areas in LMICs. Explanatory models of mental illness held by rural people in many of the countries need to be explored and addressed if this gap is to be reduced (Kurihara, Kato, Reverger, Gusti Rai Tirta, Kashima, 2005). These explanatory models are often rooted in local cultural and religious beliefs and values, which suggests for interventions which are culturally sensitive to specific groups of people in an effective way. All these suggestions can help to bridge the gap in scarcity of professional.

In many developing countries, including those in sub-Saharan Africa, the low budgets, coupled with the acute shortage of Western trained mental health professionals, has led to a situation where traditional healers are the health care providers of choice for individuals, families and communities (Atindanbila & Thompson, 2011). Some studies have even suggested that up to 80% of people in most African and other developing countries consult traditional healers at some point in their lives (Atindanbila & Thompson, 2011; Chavunduka, 2001; Helwig, 2009). In Zimbabwe, for example, patients have been reported to be showing preference for traditional medication or healing before or instead of seeking help in the formal health care system (Heather, Duffy & Sharer, 2012). Similar observations have been made in other African countries, for instance South Africa (Sordahl, Fisher, Wilson & Stein, 2010; Yen & Wilbraham, 2003), Ghana (Ae-Ngibise, Cooper, Adiibokah, Akpalu, Lund, Doku, & The Mhapp research programme consortium, 2010; Quinn, 2007), Kenya (Mbwayo, Ndetei, Mutiso & Khasakhala, 2013) and Nigeria (Akomolafe, n.d; Ogbebor, 2011).

At the political level, and in recognition of the potential value of indigenous healing systems, the African Union (formerly known as the Organisation of African Unity) declared the period 2001 to 2010 as a decade of African traditional medicine (Organization of African Unity, 2001; Shizha & Charema, 2011). To cite from the declaration: 'The assembly …

> *"Recognizes that Member States and their governments need to acknowledge and build upon this traditional knowledge resource-base, thereby making the goal of health for all easier to achieve by mobilizing and using these resources more effectively … ," (OAU, 2001, XXXVII).*

The African Union has realised that a lot of the African population (almost 85%) used traditional medicine which has made the assembly recognise the crucial role of this medicine. Traditional medicine has been recognised as the most affordable and accessible form of health care for the majority of Africa's rural residents. It was these kinds of developments regarding the continued use of traditional healing in Africa that motivated the need to embark on the present study.

1.2 Research problem

In recognition of the potential role of traditional healing in health care delivery, the Zimbabwe National Traditional Healers Association (ZINATHA) was formed in 1980, with the support of the new Zimbabwean government at that time. According to Chavunduka (2001), traditional healing was seen by the government as a useful system that could provide health assistance. The main aim of ZINATHA was to assist the development of traditional medicine in Zimbabwe in various ways. This has led to the legal recognition of a ZINATHA structure, which is officially known as the Traditional Medical Practitioners Council of Zimbabwe. Among others, the aim of the Traditional Medical Practitioners Council is to: regulate the activities of traditional healers (*n'angas* in Shona) in the use of traditional medicine; and work hand in hand with western trained doctors in healing people and formulating a set of ethical guidelines to prevent any unethical members (Chavunduka, 2001).

Though there is evidence to suggest the widespread use of traditional healing, the Zimbabwean government has continued to marginalize the application of traditional knowledge systems in the healthcare system along the western system in Zimbabwe (Chavunduka, 1998; Mazuru & Nesbeth, 2013). According to Chavunduka (2001), most western trained health practitioners still believe that traditional healing systems are a primitive and backward system of knowledge.

Despite developments such as the establishment of ZINATHA and global calls for the recognition of traditional healers (Mapara, 2009; Mazuru & Nesbeth, 2013; Sodi & Bojuwoye, 2011), there are very few studies on traditional healing (Chavhunduka, 2001; Magaisa, 2003; Mposhi, Manyeruke & Hamauswa, 2013). This paucity of literature was even more pronounced when it comes to systematic studies that sought to understand Zimbabwean traditional healers in terms of their views regarding the types, causes and treatment of mental illness and other conditions of ill health. The present study therefore sought to explore the conceptualisation of mental illness by Shona traditional healers.

1.3 Significance of the study

The study of this nature may make the following contributions:

- It could deepen our understanding of the conceptualisation and treatment of mental illness by traditional healers in some local communities in Zimbabwe. Such an understanding of cultural approaches to mental health could potentially add to the existing explanatory models and therapeutic methods that are currently used by Western trained mental health professionals.

- This study could also contribute towards efforts aimed at building a body of knowledge on culturally based methods of healing that can inform mental health policies in Zimbabwe and other developing countries.

- This study could inform the need for a collaborative interaction between Western trained mental health practitioners and indigenous healers in order to provide good mental health services.

- It is also hoped that the study will contribute to the development and expansion of the emerging fields of African and cultural psychology.

1.4 Definitions of key concepts

1.4.1 Conceptualisation: This is to form an idea or principle in one's mind from experience employing verbal and cognitive procedures (Colman, 2001). In the context of this study conceptualization shall refer to the ideas and subsequent perceptions and practices that Shona traditional healers have regarding mental illness.

1.4.2 Mental illness: This is conceptualized as a clinically significant behaviour or psychological syndrome that is associated with distress or disability (Butcher, Mineka, & Hooley, 2010). In the present study, mental illness will be understood to mean clinically significant behaviour that is perceived by traditional healers to be causing significant distress or disability.

1.4.3 Traditional healer: Also referred to as indigenous healers, this is a person who uses indigenous methods to bring good health to individual who are experiencing illness (Xaba, 2002). This same meaning of a traditional healer will be adopted for the present study.

1.5 Purpose of the study

1.5.1 Aim of the study

The aim of the present study was to explore Shona traditional healers' conceptualisation and treatment of mental illness.

1.5.2 Objectives of the study

The objectives of the study were:

- To determine Shona traditional healers' views regarding the types of mental illnesses;
- To establish the causes that Shona traditional healers attribute to mental illnesses;
- To identify the different treatment methods that traditional healers use to treat mental illness.

1.5.3 Research questions

- What are the views of Shona traditional healers regarding the types of mental illnesses?
- What causes do Shona traditional healers attribute to mental illness?
- What are the different treatment methods that Shona traditional healers use to treat mental illness?

1.6 Conclusion

The current chapter has provided the background to the study, which included challenges in treatment gap and the rising need for culturally sensitive treatment models in Zimbabwe. The rates of mental illness which were highlighted by various studies were highlighted. The current study makes significant contribution to those who provide mental health services in particular the Ministry of Health and Child Welfare and ZINATHA. The next chapter will discuss literature on mental illness building the research gaps which were filled by this study.

CHAPTER 2
LITERATURE REVIEW

2.1 Introduction

This chapter will start by focusing on the prevalence of mental illness in Zimbabwe. In the second part of the chapter a discussion on culture and mental illness will be given. The third part of the chapter will focus on the Western views on mental illness whilst the fourth part will touch on the conventional and nonconventional medicine debate. The last part will look at mental illness among the Shona people.

2.2 Prevalence of mental illness in Zimbabwe

The World Health Organization (WHO) has officially estimated that 40% of Zimbabweans are suffering from mental illness (Staff Reporter, 2009). A survey of mental disorders in Harare's low income suburbs in 2006 indicated a prevalence of 36%. Another study, focusing on 14 countries has shown that in developing countries, between 76%-85% of serious cases of mental illness did not receive any treatment in the previous year (WHO, 2006). According to Dr Benedetto Saraceno (the Director of the Department of Mental Health for World Health Organization), it is estimated that more than 90% of all cases of suicide are associated with mental disorders such as depression, schizophrenia and alcoholism. Based on these figures, it is evident that there are significantly high levels of mental illness globally, more especially in the developing countries where these cases are not adequately treated by the Western health care system. In Zimbabwe, it has been estimated that common mental disorders accounted for about 15.7% of the disease burden (Patel & Kleinman, 2003). In 2004 the commonest causes for admissions in psychiatric institutions in Zimbabwe were epilepsy (56%), followed by schizophrenia (39%), depression (less than 5%), mental retardation (about 2%), anxiety (about 2%) and other disorders (about 2%) (The National Health Strategy for Zimbabwe, 2013).

2.3 Culture and mental illness

2.3.1 Universalist versus culture relativist views on mental illness

There are two major competing perspectives concerning the relationship between culture and mental Illness. These are the universalist and cultural-relativist views on mental illness. Universalism, which is a dominant view based on biomedical sciences, assumes that the underlying psychological processes, including the manifestation of mental illness are the same across all cultural groups (Mkhize, 2012). In other words, the manifestation of depression will be the same whether the patient is in Europe or Africa. The major problem with this perspective is the tendency by health practitioners to impose a Euro-American view to understand deviant behaviours observed in other countries (Mkabela, 2005). Cultural-relativism, on the other hand, takes a view that it is impossible to speak about mental illness without taking in to account the cultural context in which this behaviour occurs (Mkhize, 2012). In other words, conditions like depression should not be understood as necessarily universal, but as manifestations of Western psychological processes that are culturally determined (Mkhize, 2012; Sodi & Bojuwoye, 2011).

2.3.2 How culture affects psychiatric disorders

Specific names have been given to culture-specific disorders and are documented in anthropological literature even though they are not part of western psychiatry standard nomenclatures. These include ‘koro’ in China (Palthe, 1936). Leighton and Hughes (2005) state that such conditions consist of symptoms known in a given culture, and have been found to have association between cultural beliefs and symptoms. Western perspectives have viewed medicine man and holy man (*shaman or sahu*) as being recruited from unstable group within a culture (Kroeber, 1952). The behaviours the *shaman* have been viewed to indicate disorders because of emotional lability, belief that *shaman* loses identity as he is possessed by a supernatural power-spirit. However, Leighton and Hughes (2005) state that even though the *shaman*’s behaviour resemble psychiatric symptoms, it is not a fact that warrants for an assumption that psychiatric condition has been met. This is because his behaviour is in line with his/her role as *shaman*, even though it may or may not

be related to his/her personality which would meet mentally ill diagnosis in Western perspective. This situation calls for consideration of cultural patterns in making a diagnosis. This gap in research is supported by Starkowitz (2013) who found that cultural variations appear on how mental illness like depression is understood by all cultures. In the presence of these variations, Starkowitz further suggests that a purely westernized perspective will may not be effective in treating an African client.

An interesting point is that the shamanistic behaviour is an honoured ritual during which the sick people will be healed or divine messages for the future are communicated. The global mental health is concerned about improving access to health care for people with mental illness and this can be achieved through respecting cultural values of all people and increasing access and recognition of traditional health care system. It is a source which has been helping people and has a deeper understanding of cultural norms.

2.3.3 African traditional conceptualisations of mental illness

Unlike Western views that tend to dichotomise the mind and the body, African cosmology on the other hand, views the body and mind as inseparable (Boyomi, 2011; Levers, 2006). In other words, the clear dichotomy that exists between physical and mental illness in western culture may not be so pronounced in the African community. This sentiment is also expressed by Bojuwoye (2005) who suggests that the African world view is based on spiritual and communal paradigms. Humans' spiritual root is thought to govern and is responsible for the manifestations of health and illness. There is a belief that both natural and supernatural factors cause illness although this is culture-specific based on theories. Nwoko (2009; Monteire & Wall, 2011). Sow (1980) suggests that illness can be caused by a number of factors such as transgression of societal prohibitions, the harmful intentions of others, unhappy ancestors and spirits possessions. An example of evil intentions was suggested by Nyame and Biritwum (1997) and Haddock (1993) whose studies found that in central Africa and Sub-Saharan Africa, epilepsy is attributed to the presence of a lizard in the brain. Many studies (Mahommed & Babikir, 2013; Mangena-Netshikweta, 2003; Mushi, Burton, Mtuya, Gona, Walker & Newton, 2012) found that epilepsy is caused by caused by evil spirits.

In a study that focused on the experiences of people living with epilepsy in one South African rural community, Siriba (2014) found that epilepsy is a disease of "falling" and it was observed that cultural understanding influenced the condition. It is interesting to note that Western medicine and psychology agrees with African traditional system, by stating that individuals who suffer from epilepsy display a number of symptoms that, among others include epileptic seizures and altered consciousness (Muircheartaign & Richardson, 2012).

Variations in how all these studies conceptualise mental illness is what led Mkhize (2012) to state that it is impossible to speak about mental illness without considering the cultural context. On the other hand, Mufamadi and Sodi (2010) state that traditional healers hold multiple exploratory models of mental illness which may differ from one area to another.

A number of studies have pointed out that mental illness in many African communities is generally attributed to witchcraft and ancestral wrath (Ngobe, 2015; Muchinako, et al., 2013; Sorsdahl, et al., 2009; Maiello, 2008). Mutwa (2003) has suggested that some forms of mental illness may be indicative of a call by ancestors to have someone become a traditional healer.

Based on this cultural view, African traditional healers tend to treat mental illness using a variety of methods such as sweat lodges, talking circles, ceremonial smoking of tobacco, herbs, or 'vision quests' (AIDS InfoNet, 2008). Corrective rituals in some instances are used to bring stability to spiritual matters. According to Sijuwulo (1995), some specific practices include ritual sacrifices, the use of herbal medicines, and extended residential stays at the healer's home (AIDS InfoNet, 2008).

2.3.4 Traditional healing

Traditional healing is perceived to be the custodian of the balance between cosmic life forces (Pretorius, 2004). God is believed to be the source and regulator of this energy. Starkowitz (2013) suggests that ancestors have access to this force which makes them powerful just below God. This helps the ancestor to realign these life forces through their mediums the traditional healers. The role of the African traditional healers is to re-balance life forces depending on ancestors.

Campbell (1998) suggested that ancestors are spirits which are as good as the guardian angel. Since they are spiritual they need a medium to be able to interact with human life, and this medium is the traditional healer. Lack of connection with the ancestors may lead to disharmony as it may impact one's luck in life (Mckay, 2010). Traditional healers are needed to reconnect the individual to the ancestors again so that there will be harmony (Koptoff, 2010). Starkowitz (2013) suggests that ancestors may visit the indigenous healer through dreams. Louw, Bentley, Sorsdahl and Adnams (2013) indicate that ancestors may ask for ritual sacrifices to be performed in order to restore harmony. Crawford and Lipsedge (2004) supports this idea by stating that if an individual does not carry out specific rituals the ancestors may withdraw their protection resulting in illness. Starkowitz (2013) suggests that traditional healers only live by the ancestral instructions.

Gilbert and others (1996) argues that the spirit and the soul are at the centre of African traditional healing approach and then cannot be tested, measured or scientifically observed. This should not make it inferior to the western perspective since their basic assumptions are opposing points of departure. How best do we expect to judge the biological and spiritual approach with the same criteria? An investigation needs to be done and specific guidelines be set to assess traditional African medicine.

2.3.5 Marginalization of traditional healers

The World Health Organization has called for the recognition and use of traditional healing in the health care system in view of its perceived effectiveness and popularity. Pucktress, Mkhize, Mgobhozi, and Lin, (2002) point out that despite these efforts, traditional healers are largely marginalized by some programmes. For example, the HIV/AIDS programmes sponsored by government and non-governmental organizations have largely ignored the rol that traditional healers can play (Abraham, 2007; Ssali, et al., 2005; Chipfakacha, 1997). This has been largely based on the idea that traditional healers' aetiology is not biomedical model (Foulkes, 1992). The dominance of biomedical perspective in health care has led to traditional healers' knowledge and practice being viewed as a problem in healthcare promotion efforts. In this situation the argument is that information which is used for

planning and implementing health care education and intervention is based on single method survey which does not fully explain traditional healers' explanatory frameworks. This incomplete information in the dominant field becomes authoritative, and such decontextualization affects the effectiveness of health care access (Abraham, 2007).

Instead of working together, Western trained professionals work in isolation with African traditional healers promoting discrimination and stigma from Western trained practitioners. Colvin, Gumede, Grimwade, Maher, and Wilkinson (2003) discovered that the current collaborative work is one-sided unidirectional approach. Mbwayo, et al. (2013) and van Niekerk (2014) state that discrimination of traditional healers is a challenge in their work as they refer their patients to the hospitals, while the doctors do not reciprocate. This makes traditional healers feel that Western-trained doctors do not recognise them. There appears to be a one way referral system from traditional healers to doctors. Atindanbila and Thompson (2011) found that traditional healers are being discriminated since their work is regarded to be unscientific (Patel, 2011). It is interesting to note that van Niekerk's (2014) study revealed that many patients reported that they access both traditional African treatment and western biomedical services simultaneously, this makes it crucial for both systems to find ways to work together.

Atindanbila and Thompson (2011) state that another challenge is that most of the healers are viewed to be lacking dosage guidelines. Lack of development of clear policies on how to make links with traditional healers has left traditional healers' knowledge not protected. Literature (Monteiro et al., 2014; Saxena et al., 2007) concurs by stating that lack of funding has affected policy development and implementation.

In the middle of these challenges traditional healers do have other things which facilitate their work. Mbwayo, et al. (2013) suggested that traditional healers refer their patients to other healers who are more experienced. They also revealed that pre-payment was not a condition for treatment as there was allowance for payment after one got better. They have devised better ways of making the service accessible without sending away poor patients due to lack of money.

2.4 Mental illness among Shona people

According to Muchinako, et al. (2013), the Shona people are viewed to have a partially similar understanding to western view of mental illness. This is evidenced by terms such as *kupenga* (mental illness) and *benzi* (Mentally ill person). Mental illness is known to affect the brain of an individual leading to behaviour which disregards social and cultural norms and values. Muchinako, et al. (2013) suggest that the mentally ill person may be violent which is seen through attacking people, breaking property and may harm self or others.

The African theory of illness has led to a strong connection between healing and religion in Zimbabwean society (Chavunduka, 2001). Chavunduka suggests that the term African theory is very broad and trying to make sense of it means bringing an understanding of the relationship between ancestors, God and universe. This has led to the differentiation between natural illness and social illness. Chavunduka states that natural illness is caused by disease causing agents such as germs, bacteria and viruses, while social illnesses are said to be a result of social agents which includes witches and different spirits. Spirits, which refer to dead people, are believed to punish people who are deviating from societal norms by sending illness. This kind of illness is said to be resolved by spirit mediums who have the power to consult the dead on how to resolve the problem.

The greatest problem made by many people is their failure to recognise the need to engage practitioners of the African religion and community leaders in order to understand the African conception of mental illness and the treatment methods (Chavunduka, 2001). The reality is that many Christian Zimbabweans still value African religion or they still hold on to some African culture. Chavunduka in 2001 states that they still conduct traditional religious rituals, consult traditional healers and believe in witchcraft.

When there are social problems in life, African people request for help from the ancestors. They can access this help from the ancestors through the assistance of the spirit medium, who is an individual with the power to communicate with the dead (Chavunduka, 2001). Chavunduka states that spirit mediums are able to communicate with the ancestors when they are in a state of spirit possession.

2.4.1 Types of mental illness

Muchinako, et al. (2013) have identified three types of people with mental illness among Shona people. These include the following;

- The violent type who may attack and injure anyone or destroy any property in their way. They are usually referred to as *mapenzi* (plural for mad person). Ropes or chains may be used to restrain them from harming themselves, damaging property or wandering away.
- The non-violent individual (may be violent sometimes) tend to, talk to self, laughs alone and wanders from place to place. They are understood to be unaware of the danger which they might face and do not care about their health, safety and security.
- The passive person who tends to be slow to learn or to understand simple instructions.

Sorsdahl, Fisher, Wilson and Stein (2010) suggest that traditional healers identify the mentally ill due to their extreme behaviour which include violence, picking up garbage, talking randomly, walking for long periods of time and undressing in public. Severe disturbances are associated with mentally ill patients (Mzimkulu & Simbayi, 2006; Patel, 2001; Mufamadi, 2001; Patel, Simunya & Gwanzura, 1997).

2.4.2 Perception of mental illness among Shona people

There seem to be variations in terms of how different people conceptualise mental illness. Literature (APA, 2013; Jackson, 1991) suggests that western view of psychiatric disorders highlights psychological factors in conditions such as depression. However, Patel, Abas, Broadhead, Todd and Reeler (2001) indicated that depression in Zimbabwe represents an illness which present with somatic symptoms. Starkowitz (2013) agrees that there is cultural variation on how mental illness like depression is understood by all cultures. This suggests that there is need to understand the conceptualization of mental illness by traditional healers. In this

situation mental health practitioners should not adopt mainstream understanding of mental illness when working within the patients from African traditional system. It is not surprising that traditional African healers may not perceive other mental problems in conventional allopathic system as illness or even emotional experience. Therefore a gap exists which needs research to investigate these differences and how they can be resolved.

Interesting to note, Bieser (1991) identified the value for medical doctors to understand how patients from the traditional African context may express distress. The same is true for mental health practitioners if they are to be effective. Experience of distress is influenced by cultural frame of reference. An understanding of specific culturally relevant symptomatology would mean that a purely westernized perspective may not be effective in treating an African client (Starkowitz, 2013). Research is needed to capture this culturally relevant symptomatology.

Tangwa (2007) indicates the need to conduct further research on traditional medicine to improve and demystify its therapeutic qualities. This suggests that there is little understanding and people might be having the incorrect perception of traditional medicine. Since, around 80% of Africans are using the traditional healers in health issues, there seem to be problems in policies which have not fully embraced traditional healers' medicine. Zimbabwe has partially embraced the traditional healers system through the formation of ZINATHA. However there is need to investigate their integration into the health system by focusing on their challenges and factors facilitating their work.

Building knowledge and awareness by exploring traditional African perspective on mental health will help to develop possible theoretical frameworks of mental health in traditional African medicine. An understanding of culture will help to inform the specific conceptualization of normality which may cover speech, behaviour and verbal expression of distress (Starkowitz, 2013). The western perspective understand mental illness using the biological approach. Conversely, Herman (1996) suggests that mental illness is socially constructed. Variations in cultural characteristics should be explored. Pretorius (2004) states that spirituality is central to cultural influence of traditional medicine. Surprisingly Fernando (2003) indicated that psychiatry and psychology do not embrace spiritual influence. In this situation,

Beiser (1991) is right to suggest that the paucity of research in African traditional medicine may result in incomplete assessments, incorrect diagnoses, inadequate or ineffective treatment.

It is noteworthy that some authors like Msotho, Louw, Calitz and Estehyse (2008) suggest that some depressive symptoms may be completely absent or increase from one culture to another. This questions the authenticity of imposing the western understanding of mental illness without considering cultural differences and interpretations. Therefore there is need to question western research or clinical psychiatry through aggressive research on African traditional conceptualization of mental illness and its treatment.

Shona people view mental illness as a disease which affects the brain or mind leading to effect on normal functioning. Shona people believe that most people experience mental illness at socially acceptable level. Any experience which goes beyond societal norm becomes a matter of concern. This is supported by experience of behavioural changes referred to as mild mental illness at certain times in the lunar circle (mwedzi *uri mutate*) (Muchinako, et al., 2013). Society tolerates this condition and it is known as *mhengera mumba*. This individual experiences periods of abnormal behaviour lasting for a few days but they can function as evidenced by playing their social role, though not at optimum levels (Muchinako, et al., 2013).

Muchinako and others (2013) suggest that mental illness among Shona people has a number of causes. Social attitudes towards the mentally ill are said to be influenced by the cause of the ailment. An afflicted person who is innocent when considering the cause of mental illness receives sympathy and support while one who is to blame is ridiculed and scorned. Muchinako and others (2013) suggest that Shona people believe that in some cases mental illness may be prevented by avoiding practices or behaviours which cause it. However, when supernatural causes are involved mental illness cannot be prevented.

2.4.3 Causes of mental Illness

According to Muchinako, et al. (2013), Shona people have different ways of explaining the causes of mental illness. These causal explanations include the following:

- Heredity: The belief here is that mental illness can be inherited from the family.
- Natural causes: In some cases, it is believed that one can be born with a poorly developed brain function.
- Avenging spirits (*Ngozi)*: In the context of the Shona culture, it is believed that evil deeds like killing someone can result in the mental illness for the perpetrator of the crime. In this case it is believed that the spirit of the murdered person (*mweya wemunhu akapondwa*) will haunt the murderer making him to be mentally disoriented. At times, the avenging spirits may bring to the perpetrator and his/her close relatives misfortune, unexplained sickness and even death. Gelfand (1982) points out that the solution in this situation may lie in the afflicted person consulting a traditional healer (*n'anga*) who has ability to explain the compensation and rituals which must be performed to resolve the situation.
- Ancestral spirits: Within the Shona culture, the living are expected conduct traditional rituals as may be prescribed by ancestors from time to time. Failure to do so is believed to lead to punishment by the ancestors. One such form of punishment could be mental illness that is brought about by the ancestors.
- A call to become a traditional healer: In some cases, it is believed that if the ancestors have chosen someone to become a spirit medium (*svikiro*) they will cause him/her to become mentally ill. The only way for such a person to escape from the mental illness is to heed the ancestral call by undergoing the training to become a traditional healer.

- Witchcraft: Muchinako, et al. (2013) believe that witches (*varoyi)* are able to cast evil spells and cause mental illness. They are believed to be driven by envy of the achievement of others. Their tools are believed to be spooks, owls, hyenas and snakes (*zvidhoma, mazizi, mapere nenyoka*) which can be commanded to strike a particular individual resulting in some form of mental illness (Last & Chavunduka, 1986).

- Ageing: Ageing (*kuchembera*) is believed to result in slowed mental functioning which, in turn, may lead to mental illness (Muchinako et al., 2013).

- Magic charms: Muchinako, et al. (2013) are of the view that acquiring magic charms (*kuromba)* is believed to provide security and prosperity for someone who acquires these. There are however strict instructions (*muko*) which come with the magic charms. Failure to adhere to these instructions is believed to result in serious consequences such as mental illness on the part of the non-adhering individual.

- Love portions (*mupfuhwira*): Gelfand (1982) states that love portions may be obtained from some traditional healers. They are aimed at strengthening the bond of love between husband and wife. Muchinako and others (2013) believe that love portions affect the functioning of the brain which may result in mental retardation and mental illness.

The causes of mental illness identified by Muchinako, et al. (2013) support the findings by Machinga in (2011) who found that illness has observable sings and some underlying unforeseen causes. This leads to the need to explore social and spiritual situations to discover the possible cause of the physical discomfort. Machinga's (2011) study among the Shona community also found that health is from cultural understanding of the role of the family and spiritual world in human welfare. Illnesses are viewed by Shona culture to have physical, social and spiritual causes. Machinga suggests that illness may indicate disharmony in one's boy, family, society or the spiritual world. In diagnosing their clients, traditional healers explore what has been happening using an unseen but present ancestral spirits.

Abbo (2011) states that traditional healers can recognize symptoms of severe illness and have expressed strong belief in the supernatural factors as the main cause of mental illness. Saravanan, et al. (2007) indicated that 70% of patients in South Indian community consider spiritual and mystical factors as the causes of mental illness. Sorketti, Zainal, and Habil (2011) are also of the same view as they point out that most people in a Sudanese community perceive mental illness to be caused by spiritual and mystical factors.

Karimi and Eschenuer (2006) suggest that African communities are directed by certain code of moral ethics. In other words common psychological illness may be perceived in some traditional African communities as consequences of immoral behaviour.

2.4.4 Dealing with mental illness in Shona society

Muchinako and others (2013) state that in order to deal with mental illness the Shona people first establish the cause of the illness and explore ways of dealing with the illness. Traditional healers (*n'anga*) are the ones that diagnose and treat the illness (Gelfand, 1959). Shoko (2007) supports the view of Gelfand by stating that for Shona people no diagnosis is complete without a spiritual diagnosis and treatment. Moodley (2005) states that good health comes from equilibrium in all areas of the patient's life. Only traditional healers will be able to provide the equilibrium in terms of spiritual forces in the patients' life. Traditional healers usually share similar customs and experiences with their patient which facilitates an understating of the problem and an understanding with their patient (Mufamadi, 2001). Hall and Marimba (2001) supports this by stating that Western therapeutic methods will not be effective in addressing problems of individual from a diverse culture. Tsala-Tsala (1997) further buttress this by stating that misdiagnosis of a client happens mostly when a therapist work with clients from a culture different from theirs.

2.4.5 Treatment of mental illness among Shona people

A study conducted by Machinga (2011) among the Shona community revealed that traditional healers are well informed about herbs, roots and foods which can prevent, protect and cure. This study further revealed that those seeking assistance from a traditional healer should have confidence in the healer. In the process the traditional healer has the task of dealing with the unseen mystrious forces and conveying messages from the spiritual world.

Muchinako, et al. (2013) state that Shona people believe that to achieve effective treatment spiritual forces must be dealt with. In a previous study, Machinga (2011) found that traditional healers use a number of methods such as divination, cleansing rituals, protective amulets and herbs in their work. They may draw insight and new meanings from dreams, also some gather knowledge on healing. Machinga futher suggested that when ancestral spirits have withdrawn their protection, the affected individual may be instructed to conduct confession, pacification and compensation in order to restore health. Bourdillon (1975) also suggest that certain illnesses can only be treated through involving the spiritual world.

The Shona people are believed to consult the traditional healers or faith healers before or soon after receiving modern medicine. This view is shared by Last and Chavunduka (1986) who state that Shona people are known to leave modern hospital care for traditional or faith healer's therapies. Abbo (2011) supports the view of rapid growth and acknowledgement of complementary and alternative medicine (CAM) provided through traditional healing being popular globally. This is evident in high income countries through increase in patients seeking CAM healers for mental health care

Muchinako et al. (2013) state that when mental illness is caused by avenging spirits (*ngozi*), the only solution seen by the Shona people is to conduct restitution (*mushonga wengozi kuiripa*). Here the belief is that western medication alone will not resolve the problem without traditional rituals. There is need to provide other forms of healing as people may sometimes suffer from 'culture bound' syndromes (Ogana, Ngidi & Zulu, 2009). Machinga (2011) states that conducting rituals and cleansing ceremonies are done to remove the evil spirit tormenting an individual, and dreams are interpreted and that information is used to prescribe healing. Gelfand (1965)

states that in order to restore health a patient may be required to ingest certain herbs. Gelfand pointed that most *n'angas* heal through divination and have powers from spirit of a relative who died (*mudzimu*). Shoko (2011) states that traditional healers work for the benefit of the society, and may have apprenticeship with the learner gaining traditional medicine knowledge through instruction. The ability to heal depends on the relationship with the ancestors which is strengthened through sacrificing animals and following instructions strictly to appease the spirits.

Chavunduka (2001) states that Zimbabwean Shona people believe that people do not die, but they pass on from this world to another which is the world of spirits. These spirits are believed to punish the living people when offended and one way is through sending illness. In these situations the spirit mediums have the ability to communicate with the 'dead' to get an understanding about illness and how to resolve it. Medication may be prescribed adding to the rituals which were performed.

Ross (2008) mentioned that spiritual pollution, where people are considered to be ritually impure due to engaging in an activity believed to be unclean, requires treatment conducted by cleansing patients and their family of evil spirits. Levers (2006) stated that traditional medicine has shown to have several benefits which include psychological relief from ailments and reduced anxiety through a shared, unquestioned and unwavering belief in the powers of the healer. Abbo et al. (2008) in Uganda also concluded that traditional healers make a contribution to the provision of mental healthcare services. They further stated that the currently available resources will require biomedical mental health service providers to engage traditional healers to ensure that appropriate mental health is accessed by those who need it.

Nelms and Gorski (2006) stated that usually older African women in rural communities, use the traditional healer's timeless and ancient caregiving when faced with symptoms of mental and physical illness. Ngoma and colleagues (2003) supports African traditional healers by stating that studies have shown that the number of common mental disorders recorded among patients consulting traditional healers is twice as great as that recorded for those attending a primary health care clinic. Also Kurihara, Kato, Reverger and Tirta (2006) concluded that traditional healers are an effective provider of care for some mentally ill patients in Bali. They

made that conclusion from observing that the knowledge and recognition of psychological disorders by the traditional healers were crucial for early treatment intervention for psychiatric patients.

The findings that clinicians, native/religious healers and nurses are the main carers involved in the management of patients with psychological problems, are confirmed by the results from developing countries like Ghana (Appiah-Poku, Laugharne, Mensah, Osei, & Burns, 2004) and Nigeria (Abiodun, 1995). This is contrasted in Mexico where most patients preferred seeing the primary health practitioner as the first carer (Gater, et al., 1991). This finding is similar to findings in Ilorin, Nigeria (Abiodun, 1995) and, Ethiopia (Girma & Tesfaye, 2011), but different from findings in Kumasi, Ghana (Appiah-Poku, et al., 2004) where there is lower use of traditional healers as first carer. Girma & Tesfaye (2011) state that traditional/native healers play a significant role in provision of care to people with mental health problems. At this point it is important to discover what makes traditional healers to be the first carers and/or play a significant role in mental illness treatment.

In a quest to understand mental health, there is need to investigate the conceptualization by traditional African medical perspective. This is due to the fact that some conditions considered to be mental illness in western perspective may not be conceptualized as such in the traditional African discourse, and the reverse may be true also. Considering that Ngoma, Prince and Mann (2003) pointed that mental illness is influenced by theory of misfortune, ancestry and witchery. This means they are not disorders but some consequences of social, physical, religious disharmony. As suggested by Maiello (2008) their treatment should be involving biological, psychological and spiritual dimensions.

2.4.6 Mental illness and modernisation among Shona people

Muchinako and others (2013) suggested that Shona people believe in spiritual forces influencing causes, diagnosis and treatment of mental illness. Since there are effective alternative approaches and psychiatric services are not easily accessed by the majority of Zimbabweans. The traditional healers and faith healers are many and easily accessed and providing a culturally relevant treatment plan. Shetty (2010)

states that the World Health Organization suggest that up to 80% of the world's population use traditional medicine for primary health needs. Nkatazo (2010) supports Shetty with local evidence that, the Zimbabwean Parliament Health Committee in 2010 reported that more than 80% of Zimbabweans use traditional medicine. All this points to the promotion and integration of traditional medicine into the mainstream health care system being of crucial value. This suggests that traditional healers and faith healers are a service which can be explored, improved and be made more accessible for the benefit of society.

Spirit mediums play an important role in the health of Shona people. African Religion and medicine is linked together by spirit mediums who are religious and health specialists at the same time. Healing and religion is strongly connected by the African theory of illness. Chavunduka (2001) states that this theory explains illness and disease, and also the relationship between ancestors, God and the universe. The theory views illness as being natural and social illnesses. Natural agents to illness include germs, bacteria and viruses while social agents include witches and spirits of various kinds. The western perspective can treat natural agents, but not the social agents. It is after considering this information that the aims and objectives of this study were coined.

2.4.7 Diagnostic manuals and the spirit component of African tradition

Spiritual possession has been mentioned in African tradition as a cause of mental illness (Abbo, 2011; Chavunduka, 2001; Mkhize, 2012). Pfeifer (1999) states that mental illness is explained as the result of magical rituals or witchcraft, resulting in emotional distress and culturally abnormal behaviour. According to previous studies (Pfeifer, 1999; Viachos, Stavroula & Hartocolis, 1997) magical-religious beliefs involve curses, ritual use symbols, voodoo practices or evil 'eye'. These have been found to be existing even in more developed countries. Spiritual possession has been rarely recognized in diagnostic manuals, with exception in context of delusional thinking. A wide spread call for more culturally sensitive diagnostic manual has been proposed.

Even though culture bound syndromes have been recognised, the beliefs in spiritual influence (such as demons) in patients does not always correlate with criteria of ‘possession’ in the strict sense of the word (Pfeifer, 1999). But, Spilka and McIntosh (1995) suggest that there has been efforts to give meaning for distressing experience of mental disorder (such as depression) within the framework of religious convictions. In this sense cultural sensitivity is still lacking and more research will push towards the respect of different views on mental illness leading to integration and improvement in health services. This study is focused on building information which will add to providing information and supporting what is there to improve healthcare.

2.5 Concluding remarks

The aim in this chapter was to review the literature on mental illness, with special focus on the prevalence of mental illness and the Shona cultural notions on the types, causes and treatment of mental illness. In the chapter that follows, the theoretical perspectives on mental illness will be presented. The researcher will also focus on the theoretical framework that is the lens through which the conceptualisation of mental illness by Shona traditional healers was understood

CHAPTER 3
THEORETICAL PERSPECTIVES ON MENTAL ILLNESS

3.1 Introduction

This chapter reviewed the theories which are relevant in explaining the conceptualisation and treatment of mental illness. The first theory is the psychodynamic theory which places emphasis on the effect of childhood traumas and the unconscious motives. The cognitive behavioural theory is also highlighted focusing on how faulty thinking affects emotions and behaviour leading to mental illness. The existential theorists recognise that human behaviour is shaped by biology, culture, and luck, while the humanist approach assumes interrelatedness between an individual's psychological, biological, social, and spiritual dimensions. In the last part of the chapter, the researcher presents the Afrocentric perspective which is the theoretical framework that underpins the present study. The Afrocentric perspective posits that Africans should be at the centre of defining, diagnosing and treating mental illness in a culturally sensitive manner.

3.2 Psychodynamic theory of mental illness

Sigmund Freud (1856-1939) was the first to challenge the view that mental illness is caused by physical agents (Freud, 1940). Instead, he argued that that the interplay of intra-psychic forces like the id, ego and superego played a significant role in the causation of mental illness. His second assumption is that behaviour is influenced by different levels of consciousness and ego defences. The third assumption is that behaviour is influenced by early childhood experiences. The psychodynamic perspective emphasises the impact of unconscious conflicts and interplay of intra-psychic events in psychological well-being and ill health.

Freud saw the id consisting of sexual, aggressive instincts and being concerned with immediate gratification. It is unconcerned with how one gets their needs, but just achieving gratification. The ego is the rational part of the mind which is concerned with behaving in a socially acceptable way. It operates on reality principles which helps to balance the desires of the id with the control of superego. The superego is a person's conscience which is concerned with moral judgements and feelings of guilt.

The above personality sturctures would contribute to psychopathology under the following situations. A health person has a strong ego which enables coping with demands of the id and superego by allowing each to express itself appropriately. A weak ego would result in either a stronger id or superego dominating the personality. Also uncontrolled id impulses may be expressed in self-distructive and immoral behaviour (Kramer, 2010). It might lead to dangerous behaviour such as psychopathy in adults. A powerful superego may be too harsh and flexible in its moral values. This will restrict the id to an extent that the person will be deprived of socially acceptable pleasure. Freud suggested that this could create anxiety disorder (Freud, 1933).

The ego defense mechanisms protect the ego from potentially damaging demands of controlling the id and superego. Repression is when unacceptable or traumatic desires, wishes, emotions and memories are hidden in the unconscious mind (Kramer, 2010). Repressed memories in the unconscious mind still have influence over behaviour while the person cannot consciously control them. If any individual does not come to grips with the experience it may come to haunt them causing mental illness. Projection is when a person sees their undesirable traits in another person. Extreme projection can lead to paranoia. Denial is refusal to accept that the truth of a fact or experience. It can prevent one from incorporating unpleasant information about oneself and his/her life and may have potentially destructive consequences (Kramer, 2010).

Even though Freud and many of his followers believed that people use defense mechanisms to combat aggressive feelings, defense mechanisms apply to a wide range of reactions from anxiety to insecurity. They seem to be people's commonest way to cope with unpleasant emotions (Kramer, 2010).

According to Sigmund Freud, human behaviour is aimed at reslving inner conflicts that develop in childhood as a child learn to master needs of each stage and deal with them. The failure to resolve these conflicts mean that an individual cannot proceed to high developmental levels. These inner conflict and instinctual energy influences human behaviour (Wade & Tavris, 2006).

Sigmund Freud's theory has been criticised for its lack of objectivity, and the fact that its theoretical constructs like the unconscious, are difficult to prove (Kihlstrom, 1999). In other words, the main criticism is that it is difficult to test Freud's methods as these depend on unobservable constructs (Barlow & Durand, 2005). Kline (1989) partially concurs that the psychodynamic approach comprises a series of hypotheses, some of which are more easily tested than others, and some with more supporting evidence than others. It is important to note that while the theories of the psychodynamic approach may not be easily tested, this does not mean that they do not have strong explanatory power. However, the researcher was looking for a theory which could sufficiently address the problem under study without creating significant doubt.

Another individual of interest in psychodynamic theory is Carl Jung. He developed his own theories systematically under the name of analytical psychology. Jung's concepts of the collective unconscious and of the archetypes led him to explore religion in the East and West, myths, alchemy, and later flying saucers (Cambray & Carter, 2004, Jung, 1964).

Jung believed that these blueprints are influenced strongly by various archetypes in our lives, such as our parents and other relatives, major events (births, deaths, and others.), and archetypes originating in nature and in our cultures (common symbols and elements like the moon, the sun, water, fire, and others.). All of these things come together to find expression in the psyche, and are frequently reflected in our stories and myths. The religious and mystique experiences are also governed by archetypes (Cambray & Carter, 2004).

Regarding the claim that all humans exhibit certain patterns of mind, Popperian critic Ray Scott Percival argues that these common patterns could be explained by common environments (that is, by shared nurture, not nature). Because all people have families, encounter plants and animals, and experience night and day, it should come as no surprise that they develop basic mental structures around these phenomena (Percival, 1993). This has been the subject of contentious debate, and Jung critic Richard Noll has argued against its authenticity (Cambray & Carter, 2004).

Douglas and Douglas (2010) suggest that archetypes reduce cultural expressions to generic decontextualized concepts, stripped bare of their unique cultural context, which has a reduction effect by reducing a complex reality into something "simple and easy to grasp". Frank (2009) found that archetypes do nothing more than to solidify the cultural prejudices of the myths interpreter – namely modern Westerners. The failure of this approach to show the richness and uniqueness of culture made it a weak theoretical framework when considering a theory which could justly explain mental illness from the lense of a specific African group.

3.3 Cognitive-behavioural perspective on mental illness

The cognitive-behavioural perspective suggests that psychological disturbances are caused by distorted or erroneous thinking patterns and faulty learning. Negative thoughts are seen to affect the way people think which, in turn will result in problem behaviour (Mash & Wolfe, 2010). The theory posits that mental illness may result from faulty thinking and learning which results in psychological disturbances (Kaplan & Sadock's, 2007). In order to deal with these psychological disturbances that are a result of faulty learning, cognitive-behaviour therapy was suggested as the solution. Cognitive-behavioural therapy (CBT) suggests that symptoms and dysfunctional behaviours are cognitively mediated (Dobson & Dozois, 2010). This means that improvement can be produced by modifying dysfunctional thinking and beliefs.

The major goal of cognitive behavioural therapy is to help the client to identify maladaptive thoughts and to learn to replace them with adaptive thoughts. At times the challenges are resolved by conducting proper problem solving which develops skills (Mash & Wolfe, 2010). In this case, it is acceptable to suggest that mental illness results from faulty thoughts and learning.

Margitics (2009) suggest that this theory places emphasis on describing and challenging the links between thinking, feeling and acting.

3.4 Existential-humanistic perspective on mental illness

Existential and humanistic perspective are united by their need to understand human experience through focusing on the client rather than the symptoms. The existentialists posit that the central problem faced by people are rooted in anxiety over loneliness, isolation, despair, and, ultimately death. According to Price (2011), existentialists hold the view that problems come from failure to exercise choice and judgement. He further suggests that each individual is responsible for making meaning out of life. On the other hand, the humanists assume that people have an inborn capacity towards self-understanding and psychological health.

One of the common criticisms levelled against the existential-humanistic perspective is that it tends to take an individual's responsibility towards self-understanding too far (Castellano, 2011; Mulhauser, 2011). For example, Corey (2009) argued that in some instances, it is possible that natural occurrences may take choices away from people. In this regard, he gave the example of a teenager paralysed by an accident, who may not be able to exercise the free will to make choices.

3.5. Theoretical framework: The Afrocentric perspective

In the present study, the researcher was guided by the Afrocentric theoretical framework. The Afrocentric perspective or Afrocentrism posits that African cultures, histories, experiences, and perceptions should form the central axis and a frame of reference when Africans are the center of analysis and synthesis (Asante, 1987). Afrocentrism contends that there is a need to safeguard and defend African cultural values, habits, customs, religions, behaviours, and thoughts by, ensuring that they are protected and are clear of all interpretations that are un-African. Tillman (2002) is of the view that culturally sensitive research focuses on addressing specific knowledge, world views, share orientation based on cultural and historical experience and specific behaviours which determine cultural distinctiveness (Sliep, 2009). This is in line with the use of Afrocentric theory to understand phenomenon within the African context.

Scholars like Mkabela (2005), Asante (2003) and Mkize (2003) state that the Afrocentric perspective seeks to relocate the African person as an agent in human history in an effort to eliminate the illusion of the fringes. The Afrocentric perspective is considered the most suitable theoretical framework for the present study, as the aim of the study is to explore Shona traditional healers' conceptualisation of mental illness so as to develop an African centered explanation of mental illness.

Tilloston (2013) suggests that Afrocentrism is positioned against all interpretations which are hostile to African reality. This means that there is a need to identify and appreciate the unique African contribution to the world, instead of accepting dominant explanations that present all European things as superior (Mazama, 2003). This means that mental illness has to be explained from the African perspective taking into account the experiences of the Africans themsleves. In other words, European explanations of mental health phenomena should not influence or supersede the African perspective.

Tilloston (2013) suggests that some people have failed to appreciate the Afrocentric paradigm and responded by labelling it a racial project. This idea drew support from neoliberal and radical conservative scholars whose reaction did not allow them to identify and understand the utility of Afrocentrism in a wider context of the human family.

3.6 Concluding remarks

In this chapter different theories were reviewed which sought to explore the conceptualisation and treatment of mental illness. The flaws in each theory and the strength were identified. However the Afrocentric perspective proved to be appropriate for this study since the objective was to carry out a study using the lens of Shona traditional healers.

CHAPTER 4

RESEARCH METHODOLOGY

4.1 Introduction

The previous chapters explored what is known about mental illness and its significance in the Zimbabwean context. They laid the foundation for the exploration of Shona traditional healers' conceptualisation of mental illness. In the first part of the present chapter, the research design, and in particular the phenomenological approach that was adopted for this study, will be discussed. In the second part, the setting where the study was conducted, including the reasons for choosing this particular research site will be presented. The third part of the chapter will focus on issues of sampling whilst the fourth part will look at data collection. The method that was followed to analyse the data, including the steps that were followed in this regard will be discussed in the fifth part of the chapter. Issues pertaining to quality (for example, confirmability and dependability) will be addressed in the sixth part of the chapter. The last part will cover the ethical issues that guided the researcher in the study.

4.2 Research design

The researcher chose the qualitative approach, and in particular the phenomenological method for the present study in order to allow the participants to create their own reality using their own understanding of mental illness. Their lived experiences in dealing with patients gave an insight into mental illness and how they have treated it from their point of view. This was in line with the suggestion made by Streubert, Speziale and Carpenter (2003) who have argued that the purpose of phenomenological method is to describe the way phenomena appear as a lived reality of life. In the current study whatever the traditional healers have experienced or witnessed in treating mental illness had to be understood from their point of view. Their understanding might be different from other traditional healers in other communities or nations.

Durrheim (2006) suggests that qualitative research is naturalistic in nature as it investigates real people in practical life situations. Burns and Grove (2007) understands qualitative research to be focusing on the human experience through systematic and interactive approaches. The interaction between the researcher and the participants under study leads to the discovery of information. The qualitative research approach allows the researcher to explore the meaning and interpretations of constructs (Hesse-Biber, 2010) which are rarely observed in quantitative research. Qualitative research has the advantage of flexibility as additional research questions may emerge from the data as the study progresses. This allows constructs to be interrogated intensively which is more likely to result in better insight about them. When studying people, there are intra-group differences which at times lead to the use of relativistic assumptions. In these assumptions, there is no one unitary reality but a lot of realities constructed when people experience the same phenomenon (Lythcott & Duschl, 1990). According to this assumption there is need to understand the perception of each individual while at the same time uniting the similarities and separating their views along their differences. In the current study whatever the traditional healers' have experienced or witnessed in treating mental illness had to be understood from their point of view.

The researcher opted to use the phenomenological research design for the present study as it allowed the participants to create their own reality using their understanding in their own words (Carpenter, 2007). The aim of the current study was to build an understanding of traditional healers' conceptualization and treatment of mental illness among Shona people from the perspective of the traditional healers themselves.

4.3 Study setting

The site of this study was Goromonzi District (See Figure 1) which is in Mashonaland East Province of Zimbabwe – one of the 8 provinces in Zimbabwe. Mashonaland East Province covers 9,100 km and is made up of 9 districts (ZimStats, 2012). Zimbabwe is situated in the southern region of the African continent.

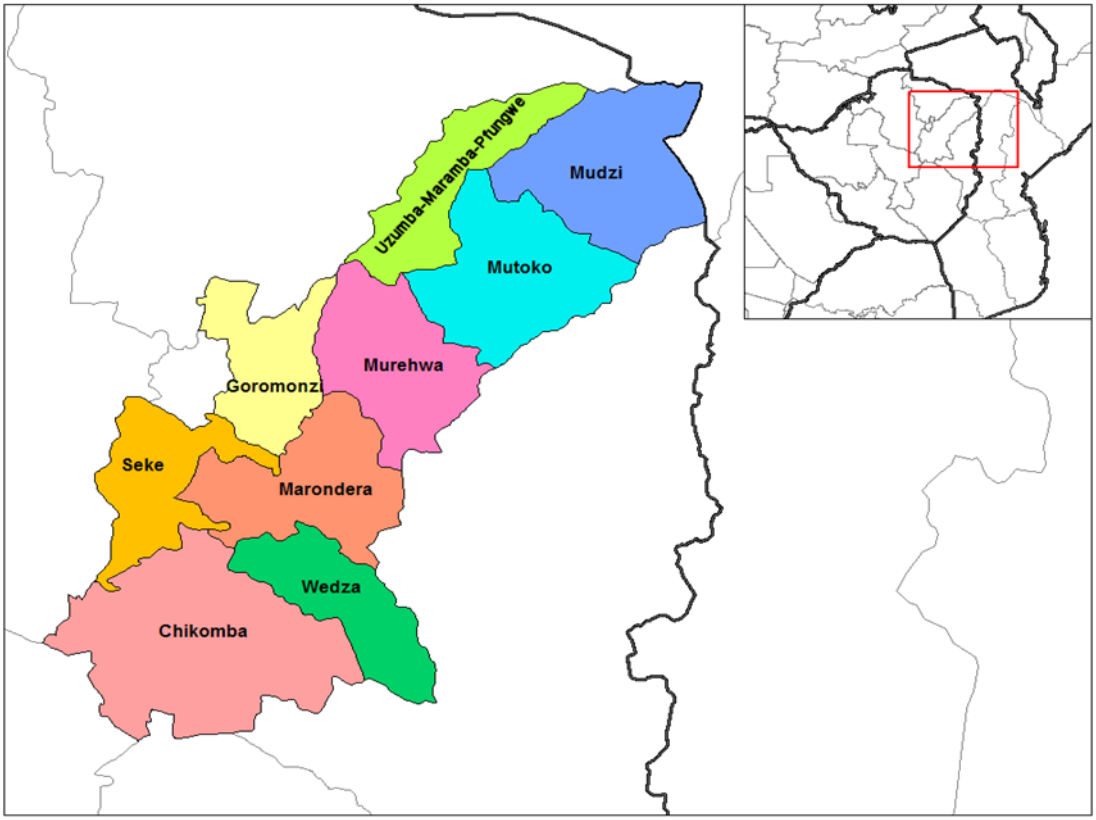

Figure 1 Map of Zimbabwe showing Goromonzi district

(https://en.wikipedia.org/wiki/Mashonaland_East_Province)

The people who live in Mashonaland East Province are mainly Shona speaking. The 2012 national census showed that Mashonaland East Province had a population of 1 344 955 people, consisting of 651 781 males and 693 174 females (ZimStats, 2012). The province makes up 10.3% of the total country's population. There is a high literacy rate for the population aged 15+ with figures suggesting a total for the province standing at 96% (male literacy = 97%; female literacy = 95%). Percentage distribution of economically active males consist of 9.2 % paid employees, 8.2% employers, 12.1% own account worker, 15.3% unpaid family worker, and 6.7% who are looking for work. Percentage distribution of economically active females consist of 9.0 % paid employees, 8.8% employers, 12.3% own account worker, 17.7% unpaid family worker, and 5.3% who are looking for work (ZimStats, 2012). The

researcher chose Goromonzi district because he was born and raised in the district and he is familiar with the place, culture and language in it.

Zimbabwe has two major languages, which are Shona and Ndebele, while English was introduced at the time when the country was colonised. There are a number of dialects of the Shona language. These include the Zezuru, Karanga, Manyika, Tavara, Ndau, and the Kalanga. The Zezuru inhabit the central plateau of Zimbabwe. The Karanga are found in the southern part of the country. The Korekore inhabit the northern part of the country and dropping into the Zambezi Valley. The Manyika are found in the eastern area of the country. The Tavara inhabit the Zambezi Valley in Mozambique and in the extreme northeast of Zimbabwe. The Ndau are found in the south-east of Zimbabwe and stretching down to the coast in Mozambique. The Kalanga inhabit the south-west of Zimbabwe and overflowing into Botswana. The Shona-speaking people comprise about 80 percent of the population of Zimbabwe (Bourdillion, 1996). Around 25 percent of the Shona people belong to a variety of Christian denominations, leaving the other 75% in traditional belief system. Bourdillion (1996) states that belief in witchcraft and sorcery is widespread among Shona people. This makes it an ideal catchment area for investigating the conceptualization and treatment of mental illness among Shona people.

4.4 Sampling

The researcher used both purposive and snowball sampling techniques to select the required number of participants for the study. Palys (2008) suggests purposive sampling, which refers to the identification and selection of a well informed and articulate informant, provides rich information than any randomly chosen sample. Palys also adds that purposive sampling provides the purest or most clear-cut instance of a phenomenon which researchers are interested in. The researcher concurs with Palys (2008) that certain individuals who meet a certain criterion are selected to provide in-depth understanding of the phenomenon. Bernard (2002) suggests that the key informants are observant, reflective members of the community of interest who know much about the culture and are willing to share their knowledge with the researcher.

According to Patton (1990), purposive sampling entails the careful selection of individuals who have rich information in order for one to develop great depth on issues that are central to the purpose of the study at hand. After considering the views of Palsy (2008), Patton (1990) and Bernard (2002), the researcher chose purposive sampling since the study was focused on people who treated mental illness and wanted to obtain information from their lens while ensuring richness in the data gathered (Fossey et al, 2002). The researcher was directed to the first participant through an informant who knew a traditional healer who was popular in the district for treating mental illness.

After this traditional healer was identified, snowball sampling was followed to identify and select the rest of the participants. Snowball sampling refers to a process in which participants are obtained through a chain referral made among people who share characteristics which form the basis for the focus of a study (Babbie, 1995). The researcher asks each of these members given by first participant if they know of any other member of their group. The people so identified are approached and requested to also identify others with similar characteristics. The process continues till a point of saturation, meaning that no more new information is obtained (Elder, 2009). Similarly, the researcher chose snowball sampling to expand on the sample from the first participant who was identified through purposive sampling. The reason was that verification of eligibility was made easy since it was not a deviant group, and the people were sharing the characteristics which were the focus of the present study. The size of the sample was controlled by saturation of information, which means that data was collected until no new themes came up or until there was repetition (Streubert, Speziale & Carpenter 2003). In this regard, a total number of 10 participants (males = 9; females = 1) was selected and interviewed for the present study. After interviewing ten traditional healers the researcher stopped recruiting since redundancy was reached (Goldberg, 2011). At this point there was saturation since the participants were no-longer introducing any new themes, as large amount of data collected repeated the same themes.

4.5 Participants' demographic information

The table below presents the demographic details of the participants.

Table 1 Participants' demographic information

	P1	P2	P3	P4	P5	P6	P7	P8	P9	P10
Age	65	47	36	50	58	60	64	64	57	68
Gender	M	M	M	M	M	M	F	M	M	M
Marital status	M	M	M	M	M	M	M	M	M	M
Employment Status	E	SE	E	SE	E	SE	SE	U	U	E
Level of Education	Pri	Ter	Sec	Sec	Ter	Sec	Pri	Pri	Pri	Pri
Age became TH	40	30	16	35	32	30	34	28	32	25
Duration as TH	25	17	20	15	26	30	30	36	25	46

Key

TH-Traditional healer *Pri- Primary* *Sec-Secondary* *Ter-Tertiary*

E- Employed *SE-Self-employed* *U- Unemployed* *M- Married*

M-Male *F- Female* *P- Participant (example, P1-First participant, P2- Second participant*

As was pointed out earlier, a total of ten traditional healers participated in this study, consisting one female and nine males. The age of the participants ranged from thirty-six year to sixty-eight years. All the participants were married. Four participants were self-employed, four were working in some private companies and two were unemployed. Two participants had some tertiary qualifications, whilst three had some secondary level qualification. The remaining five participants had no secondary school education.

The youngest traditional healer joined the profession at the age of sixteen years and the eldest at the age of forty years. The longest serving member in the profession has forty-six years in the profession. The inclusion criteria was that the participant should be a practising traditional healer who is known in the community to be treating mental illness.

4.6 Data collection

In-depth interviews were used to collect data. Data was collected over a period of four months in the identified traditional healers' homes or other locations that they preferred. Pre-testing of the research semi structured interview was done before commencing the actual study with one individual who used to practice traditional healing. This individual was excluded from the actual study because he was no longer practicing as a traditional healer. The pilot was conducted to provide a better estimate of the length of interviews and to determine any unforeseen constraints with the questions. The pre-testing revealed the need for follow up to get clarification on a few words used.

4.6.1 In-depth individual interviews

Kvale (2006) suggests that qualitative interviews are focused on understanding the world from the participant's lens with a view to uncovering the life experiences of the participants prior to scientific explanations. A similar sentiment was also expressed by Greeff (2005) who stated that semi-structured interviews permit the researcher to acquire a detailed understanding of the participant's beliefs and perceptions about the phenomenon under study. These kinds of interviews enable the researcher to follow up on certain dynamics of interest, while the participants control the depth of information that they prefer to share with the researcher. Similarly, the researcher in the present study made use of one-on-one interviews to develop an understanding of the conceptualisation and treatment of mental illness from the Shona traditional healer's point of view. Each participant was interviewed separately from the others. The aim was to have an understanding of each individual traditional healer from their own lens.

An interview guide (see Annexure 1a and 1b) was used to increase consistency across the data collected. According to Kennedy (2006) and Patton (2002), an interview guide provides the direction of the conversation toward the topics and issues you want to learn about. Based on the assertions by Kennedy (2006) and Patton (2002) cited above, the researcher found the interview guide to be an appropriate research tool that allowed for comparison of similarities and differences which emerge as the participants responded to the same research questions. Each interview lasted about an hour to an hour and half.

After receiving the names of the informants and their contact details, the researcher contacted them one by one, introducing himself and his study, then scheduling an appointment at a date and time which was convenient to the participants who were willing to participate. On the day of the interview the researcher made sure that the venue was the preferred location of the participant and that such a venue offered privacy for the purpose of one-on-one interaction. The researcher began with a scripted introduction of the study which was followed by general questions about indigenous knowledge system focusing on defining mental illness, identifying the causes, explaining treatment, identifying barriers and facilitators of the job of traditional healers.

The researcher used an audiotape to record interviews which were conducted in Shona with the permission of the participants. The interview transcripts were later translated into English by an indipendent expert. As suggested by Kelly (2006), the researcher ensured that the interviews were conducted in an empathic and sensitive manner. In this regard, the researcher made an effort to be respectful by showing willingness to comply with possible traditional rituals as he took of his shoes before getting into the consulting rooms of the traditional healers that were interviewed. Soon after the interviews the researcher captured notes of what he observed during the interview.

4.7 Data analysis

According to Terre Blanche, Durrheim and Kelly (2006) qualitative interpretive analysis is aimed at providing thick descriptions of a phenomenon by developing a real life phenomenon into specific perspective. For Groenewald (2004), data analysis means fragmentation of the information obtained into parts. For the present study, the researcher adopted the interpretive phenomenological approach (IPA) as the method to analyse data from one-on-one interviews. According to Pringle, Drummond, McLafferty and Hendry (2011), IPA is aimed at developing rich descriptions of human experience and emphasises the importance of individual accounts of the participants. In terms of the process of data analysis, the researcher followed the following steps of IPA as elucidated by Hycner (1999):

4.7.1 Bracketing and phenomenological reduction

According to Hycner (1999), phenomenological reduction to pure subjectivity refers to wilful and purposeful opening by the researcher to the phenomenon as it is without changing its meaning. Lauer (1958) suggests that suspension or bracketing out (or epoche), is when the researcher remains neutral towards the phenomenon by preventing his meanings or what he/she has learned to influence the unique world of the informant/participant (Sadala, Adorno & deC, 2001). In the case of the present study, this particular step involved the researcher remaining neutral to avoid influencing the world of the participant by transcribing audio recorded data into text without adding or subtracting anything. This involved moving the record forward and backward to ensure that the verbatim transcribing was correct. The information was transcribed onto a Microsoft Word page. It is interesting to note that themes begun to emerge as the researcher listened forward and backwards whilst re-reading the Microsoft Word pages.

4.7.2 Delineating units of meaning

During this step, statements that were seen to illuminate the researched phenomenon were extracted or isolated (Hycner, 1999). The list of units of relevant meaning extracted from each interview were carefully scrutinised and the clearly redundant units eliminated (Moustakas, 1994). In the present study, this was done by considering the literal content, the number (the significance) of times a meaning was mentioned and also how (non-verbal or para-linguistic cues) it was stated.

After repeated reading of the data of each participant, the researcher assigned codes to texts which were chunked from the data to represent a theme as suggested by Zhang & Wildemuth (2009). Each transcript was read and re-read to produce numbered texts from 1 to 8 corresponding to 'characteristics of mental illness', 'causes of mental illness', 'treatment of mental illness', 'characteristics of associated illnesses', causes of associated illnesses', 'treatment of associated illnesses', 'challenges', and 'facilitators', recording when they were expressed. The verbal and nonverbal communications associated with these texts were noted. After this, there was cutting and pasting of the narrative quotes onto the relevant category. Any new codes discovered were added to the list.

4.7.3 Clustering of units of meaning to form themes

During the third step, the list of units of meaning were examined to elicit the essence of meaning of units within the holistic context. Clusters of themes were formed by grouping units of meaning together (Creswell, 1998) and identifying significant topics, also called units of significance (Sadala, Adorno & deC, 2001). Both Holloway (1997) and Hycner (1999) emphasise the importance of going back to the recorded interview (the gestalt) and forth, to the list of non-redundant units of meaning to derive clusters of appropriate meaning.

The researcher grouped statements with a related meaning, similar words or phrases mentioned by the participants. A cluster made up of similar units was the end product for each category. A list of codes was developed to have consistency in the study. Coding allowed the researcher to find themes which overlap and those which were distinct.

4.7.4 Summarising each interview, validation and modification

During this step, each interview was taken and a summary was compiled which incorporated all the themes elicited from the data which gave a holistic context. At that point a validity check was conducted by returning to the informant to determine if the essence of the interview had been correctly captured (Hycner, 1999). Any modification necessary were done as a result of this validity check.

4.7.5 Extracting general and unique themes from all the interviews and making a composite summary

During this final step in the phenomenological explicitation process, the researcher looked for the themes common to most or all of the interviews as well as the individual variations (Hycner, 1999). Care was taken not to cluster common themes if significant differences exist. The researcher divided the coded data into themes. Each theme was studied until a meaning of each theme was concluded. Then the relationships were established while reconstructions of meaning were made through inference from the data available.

The explicitation was concluded by writing a composite summary, which reflected the context or 'horizon' from which the themes emerged (Hycner, 1999). In accordance with Sadala, Adorno and deC's (2001) guidelines, the participants' everyday expressions were transformed into expressions appropriate to the scientific discourse supporting the research.

4.8 Quality criteria

Golafshani (2003) suggests that qualitative research focuses on credibility, transferability, and trustworthiness. When conducting qualitative study the question of replicability in the results is not a concern (Glesne & Peshkin, 1992), but precision (Winter, 2000), credibility, and transferability (Hoepf, 1997) provide the lenses of evaluating qualitative research findings.

4.8.1 Credibility

To ensure credibility a sound research methodology with clearly spelt out techniques was used. The study had clear delimitations consisting of well demarcated study area and specific group of population and sample to be participants, theoretical perspective. The use of community knowledge to identify the first participant and use of appropriate person to identify informants helped to move through individuals who were seasoned traditional healers. The use of qualitative study helped to build knowledge from in-depth explanations.

The experiences of traditional healers in conceptualising and treating mental illness were captured in their own words. These became the basis of the truthfulness of this study. The research process was recorded to create an open record of traditional healer's experiences. Piloting helped to identify and edit any biased or leading questions, and this process continued in the study in order to improve an objective view.

As suggested by Merriam (1995), the researcher had prolonged engagement through spending adequate time speaking with a range of people, developing relationships and rapport with the members of the community. The researcher persistently observed characteristics and elements in the situation that were most relevant to mental illness which was being pursued and having a detailed focus on them (Lincoln and Guba, 1985). This was aimed at providing depth of the subject matter.

Member checks were made to strengthen the study's credibility (Lincoln and Guba, 1985). This was done formally as opportunities were provided for member to read any transcripts of dialogues in which they have participated. Here the emphasis was on whether the informants consider that their words match what they actually intended.

4.8.2 Transferability

To allow transferability, the researcher provided details of fieldwork, background data and description of the concept under investigation. The interview questions and protocol and detailed account of the coding process, in order to make the replication of the study easier. Input from peers helped to improve the quality of the study. The research participants were re-engaged to comment on the truthfulness of their interviews before the finalisation of data analysis. However, the researcher cannot claim absolute transferability as the findings may not necessarily be transferred beyond this sample. A large sample which is more representative may be needed to achieve this. At the same time the researcher has made considerable effort to deal with bias. It is crucial to note that the findings do provide some knowledge on the conceptualisation and treatment of mental illness by Zezuru Shona traditional healers.

Marchionini and Teague (1987) highlights the importance of the researcher conveying to the reader the boundaries of the study. The researcher provided sufficient contextual information about the field work sites in order to enable the transferability of such research inquiries (Lincoln and Guba, 1987). The researcher also indicated that findings are applicable for a particular environment of individuals (Traditional healers in Goromonzi district), it was extremely difficult to demonstrate that the findings and conclusions are applicable to other situations and populations (Merriam, 1998).

The researcher provided thick descriptions which were detailed account of field experiences in which the researcher made explicit the patterns of cultural and social relationships and puts them in context (Holloway, 1997). This provision permitted the assessment through supplying details for similar projects which will employ the same methods but being conducted in different environments.

4.8.3 Trustworthiness

Lincoln and Guba (1985) state that trustworthiness involves establishing credibility which means having confidence in the 'truth' of the findings. The researcher achieved trustworthiness by doing various activities. Firstly, the researcher sought to achieve trustworthiness by obtaining informed consent from the participants. Any questions raised before or during the interview about the research process or anything else related to the study were answered. The sample's confidentiality and anonymity were carefully protected, by changing any identifying details. Secondly, the researcher remained flexible in the research process, ensuring that the participants continued to be interested in discussing conceptualisation and treatment of mental illness. In the beginning, the researcher explained that being a participant was optional. Thirdly, the researcher asked the potential participants if they agreed to be interviewed on the subject of mental illness.

Open ended questions were used to deal with potential bias (Ronald, 2011). This did not limit participants to share their perspective on the subject matter. The researcher was a Shona speaking individual which helped to ensure that the data obtained was as authentic as possible. Traditional healers' level of expertise was respected during the interview process. The researcher developed a reflexive journal which ensured that regular entries were made during the research process. Methodological decisions, the logistics of the study and reflection upon what is happening in terms of one's own values and interests were entered in this diary in line with the recommendations made by Pandey and Patnaik (2014).

4.9 Ethical considerations

4.9.1 Permission to conduct the study

Prior to commencement of the research, the researcher sought and obtained ethical clearance from the university's Research Ethics Committee (see Appendix 1: Ethics clearance certificate).

4.9.2 Informed consent

Written informed consent was sought from the participants before conducting the present study (see Appendix 2a entitled Participant's Consent letter and Form– English and Appendix 2b entitled Participant's Consent letter and Form – Shona, Appendix 3a entitled Consent form to participate in a research study to be signed by participant – English and Appendix 3b Consent form to participate in a research study to be signed by participant – Shona). Participants were informed about the research process in order to enhance their comprehending of the study. Then made a voluntary decision about their possible participation. At the same time participants were allowed to withdraw at any time without incurring and negative consequences (Mazabaum, 2006).

4.9.3 Confidentiality/anonymity and privacy

It was the responsibility of the researcher to ensure that the privacy and identity of the research participants was safeguarded (Strydom, 2005). This was ensured by making sure that the information obtained was handled in a confidential manner. Any typed information and audio recordings were stored in a password protected file while any hard copies and audio recording machines were kept under a locked drawer.

4.9.4 Respect for persons

The researcher ensured that the dignity of all research participants was respected by ensuring that they were not be used simply as a means to achieve research objectives, but to benefit from the knowledge derived from the study. This will be achieved through the publication of the research on the university website, which makes the outcomes readily available for use by policy makers.

4.9.5 Debriefing of respondents

In line with the recommendation by Babbie (2001) the researcher debriefed each participant after the interview. The participants showed no emotional reactions that warranted a referral to a mental health practitioner. The researcher examined the relevance of the concept of mental illness for the traditional healers in the sample and they all agreed that it was relevant.

4.10. Concluding remarks

In this chapter, the research methodology used to conduct the study was discussed. The philosophical basis, including the specific steps followed in doing the research was presented. The demographic characteristics of the participants were presented and highlighted. The quality criteria and the ethical issued that guided the researcher in conducting the study were also highlighted. In the next chapter, the findings of the study will be presented.

CHAPTER 5

FINDINGS OF THE STUDY

5.1 Introduction

This study sought to understand the conceptualisation and treatment of mental illness by Zezuru Shona traditional healers in Zimbabwe. The researcher followed the five steps of phenomenological data analysis as elucidated by Hycner (1999) to process the data. What is presented in this chapter is limited to step five (namely, extracting general and unique themes from all the interviews and making a composite summary). In Part A, the data is reviewed to identify the themes and subthemes. In Part B, the psychological description and interpretation of what emerges from these themes and subthemes is given.

PART A: EMERGING THEMES AND SUBTHEMES

5.2 Conceptualisation of mental illness by Shona speaking traditional healers

The table below summarises the findings in terms of the emerging themes and subthemes related to the conceptualisation of mental illness:

Table 2: Emerging themes and sub-themes in the conceptualisation and treatment of mental illness by Shona traditional healers

THEMES	SUB-THEMES
	Subtheme 1: Disorganised behaviour and the related features **Subtheme 2:** Failure to recognise familiar people (*kukanganwa hama dzepedyo*) **Subtheme 3:** Derailment (*kurasika*

Theme 1: Types/characteristics of mental illness	*pakutaura*) **Subtheme 4:** Occupational impairment (*kutadza kushanda*) **Subtheme 5:** Falling (*kupunzika*) **Subtheme 6:** Mutism (*kunyararisa*) **Subtheme 7:** Increased or irregular heartbeat (*kurohwa nehana*) **Subtheme 8:** Headache (*kutemwa nemusoro*) **Subtheme 9:** Dizziness (*dzungu*) **Subtheme 10:** Perceptual disturbance • Tactile sensation (*kufambwa fambwa*)
Theme 2: Causes of mental illness	**Subtheme 1:** Witchcraft (*huroyi*) **Subtheme 2:** Avenging spirits (*ngozi*) **Subtheme 3:** Head trauma (*kusangana kweropa nehuropi*) **Subtheme 4:** Theft (*kuba*) **Subtheme 5:** Bad spirits which follow spirit medium (*mweya yakaipa inotevera mudzimu*) **Subtheme 6:** Love portion (*mupfuhwira*) **Subtheme 7:** Heredity (*chirwere chemhuri*)
Theme 3: Diagnosis and treatment	**Subtheme 1:** Diagnosis (*kubata chirwere*) **Subtheme 2:** Treatment methods (*nzira dzekurapa*)

of mental illness	**Subtheme 3:** Dealing with bad spirits (*kubvisa mweya yakaipa*) **Subtheme 4:** Compensation (*kuripa*)
Theme 4: Challenges faced by traditional healers	**Subtheme 1:** Treatment failure (*mushonga unotadza kurapa*) **Subtheme 2:** Anger (*kutsamwa*) **Subtheme 3:** Jealous (*godo*) **Subtheme 4:** Concerns by traditional healers around theft of ideas and intellectual property (*kuba*) **Subtheme 5:** Discrimination (*rusarura*)
Theme 5: Facilitating factors in the work of traditional healers	Subtheme 1: Remuneration for the work done Subtheme 2: Continuous professional development (*kudzidzisana*)

As can be seen from the above table, five themes associated with the conceptualisation of mental illness were extracted from the data. The first theme pertains to the types/characteristics of mental illness. The second relates to what is perceived by the participants as the causes of mental illness whilst the third theme is the participants' views regarding the treatment of mental illness. The challenges faced by traditional healers is the fourth theme whilst the fifth pertains to the factors that are perceived to facilitate the traditional healer's work.

5.2.1 Theme 1: Types/characteristics of mental illness

Most of the participants that were interviewed tended to characterise mental illness as a condition that manifests through a number of symptoms that among others include disorganised behaviour, derailment, mutism, and dizziness. Each of these specific features or symptoms is presented in the form of subthemes below:

Subtheme 1: Disorganised behaviour: Disorganised behaviour was reported by the participants to be the most common feature that is indicative of the presence of mental illness. Typical disorganised behaviour patterns include: inappropriate laughing (*kuseka zvakapfuura mwero*), talking to self (*kutaura wega*), scavenging (*kudya zvakaraswa*), bad eating habits (*kudya zvisina mwero*), poor hygiene (*kusa zvishambidza*), illogical thoughts (*kurotomoka*), and wandering about (*kusagara pasi*)

a). Inappropriate laughing (*kuseka zvakapfuura mwero*): Most participants reported that they have observed individuals who laugh in a way which is not proper for a given situation. A person fails to make a distinction between what is and what is not funny. The following verbatim expressions illustrate the theme of inappropriate laughing in the way a person behaves:

> *When a person is laughing inappropriately while you are trying to help them, may be an indication that he/she is mentally ill. This inappropriate laughing alone means that the problem has affected the normal functioning of the brain (Participant 3)*.

The above extract seems to suggest inappropriate laughter is one of the symptoms that will give an indication of a mental illness.

b). Talking to self (*kutaura wega*): Most of the participants stated that they have observed individuals who behave as if they are having a conversation when in fact they are talking to themselves. This kind of behaviour was interpreted by some participants as an indication that a bad spirit might be fighting with the ancestral spirit of the person. The following extracts illustrate this:

> *Every person has an angel or ancestral spirit that protects them. If the evil spirit descends on a person with a strong ancestral spirit or strong angel the two will begin to fight. The affected person will become illogical in their speech (kurotomoka) and will begin to talk to themselves, saying things like "You will not kill me" (Participant 4).*

You can discern that someone is mentally ill when you are talking to them. For example, the person might say "I am so and so, and I want to see my cattle. Why are you not bringing back my cattle?" A person displaying this kind of behaviour will be mentally ill (Participant 1).

Talking to self was reported by the participants to be one of the indications of disorganised behaviour. Often such behaviour appears to be associated with one or more spirits that are communicating. For the mentally ill person, these kinds of communications with invisible entities will be experienced as real. A person like a traditional healer who is understood to have some spiritual powers will be able to assess and diagnose the problem.

c). Scavenging (*kudya zvakaraswa*): Some of the participants reported encountering people who collect and eat garbage. According to the participants, these mentally ill people will be convinced that the garbage they eat is some kind of delicious food. For such a mentally ill person, there is nothing wrong in what they are doing. The following verbatim expressions illustrate this:

You will see these people picking up and eating rubbish and food that has been thrown away by others. The mind of such a person is no longer operating well, because he/she will be mentally ill (Participant 2).

These people do not have a problem eating left-over food from the rubbish bin (Participant 7).

As can be seen from the above extracts, scavenging is interpreted by the participants to be one of the indications of disorganised behaviour, which is one of the symptoms that suggests the presence of mental illness.

d). Bad eating habits (*kudya zvisina mwero*): Most of the participants indicated that mentally ill people fail to restrain their behaviour when they see food. The following quotations illustrate this point:

A person who is mentally ill will not show good manners when they eat food. This means that the brain is no-longer functioning well (Participant 9).

You will see the person eating food in a disgusting way without realising it (Participant 1).

For the participants, the above examples of inappropriate eating habits are a reflection that the person that they are dealing with is mentally disturbed.

e). Poor hygiene (*kusa zvishambidza*): According to most of the participants, poor hygiene is one of the indications of mental illness. People with mental illness tend to prefer dirty clothes and would also refuse to bath. The following verbatim expressions by the participants illustrate the theme of poor hygiene:

... *they may wet or soil themselves (Participant 8).*

A person would not want to bath and will prefer to remain dirty (Participant 5).

The participants are of the view that a person engaging in poor hygiene has no capacity to make a distinction between good and inappropriate behaviour.

f). Illogical thoughts (*kurotomoka*): One of the common symptoms of mental illness identified by the participants is *kurotomoka* (illogical thoughts). The quotations below were extracted from the participants` narratives to help illustrate the way illogical thoughts were understood:

You and a person with mental illness will not understand each other (Participant 10).

The person will be illogical in his/her speech (kurotomoka) saying "You will not kill me". … These will not be this individual's words (Participant 6).

Failure to be logical in one's thinking seems to be reflected in unintelligent speech. Based on such inappropriate speech, the participants are in a position to interpret this as a reflection of mental illness.

g). Wandering about (*kusagara pasi*): The participants reported that mentally ill people tend to wander aimlessly as reflected in the extracts below:

> *A mentally ill person will not be settled and will find it difficult to stay at home. They will move from place to place without resting (Participant 1).*
>
> *A mentally ill person will move from place to place while refusing to stay at home or being in the house (Participant 9).*

As can be seen from the examples above, it does appear that disorganised behaviour is one of the common features that shows the presence of mental illness. This appears to be discerned from a wide range of inappropriate actions that include inappropriate laughing (*kuseka zvakapfuura mwero*), talking to self (*kutaura wega*), scavenging (*kudya zvakaraswa*), bad eating habits (*kudya zvisina mwero*), poor hygiene (k*usa zvishambidza*), illogical thoughts (*kurotomoka*), and wandering about (*kusagara pasi*).

Subtheme 2: Failure to recognise familiar people (*kukanganwa hama dzepedyo)*

According to most of the participants, failure to recognise familiar people including one's own relatives is one of the signs of mental illness. The failure to recognise familiar people is attributed by the participants to foreign spiritual forces in the life of a mentally ill person. The quotations below illustrate this point:

> *If a person is mentally ill, she/he does not recognise close relatives. For example, a person with mental illness may fail to recognise his own father. A foreign spirit will have entered the person and as such he/she may not recognise his/her own relatives (Participant 4).*

Failing to remember the names of people close to you is a sign of mental illness (Participant 6).

It does appear that failing to recognise others is perceived as something that is brought about by external factors like some foreign spiritual forces. In other words, an alien spiritual force is perceived to be responsible for the affected person's mental illness.

Subtheme 3: Derailment (*kurasika pakutaura*)

The participants indicated that mentally ill people fail to maintain a specific line of thought. Those with mental illness tend to suddenly change the subject in a conversation to the extent that this will confuse the person that they are talking to. In other words, mentally ill people tend to vacillate between sensible and senseless talk. The following extracts are an illustration of this:

A person with mental illness will keep on vacillating between meaningful and meaningless communication. At some point, such a person may even switch to vulgar words without any provocation (Participant 6).

Let us say we are talking about something and all of a sudden you change the topic of our conversation. Then suddenly you are lost and you ask me as to what we are talking about. You see, such a person cannot maintain a conversation without interruptions. Their minds are no longer a good condition (Participant, 2).

Failure to maintain a meaningful line of thought is perceived, according to the participants, as indicative of mental illness.

Subtheme 4: Occupational impairment (*kutadza kushanda*)

According to the participants, significant disturbance in terms of occupational functioning is one of the indications of mental illness. In other words, a mentally ill person may no longer be able to work and this will affect productivity. The quotations below illustrate the participants' views on this matter:

> *The person will not be able to control him/herself. He may no longer be able to go to work (Participant 10).*
>
> *One may fail to do his/her daily activities effectively. They may also fail to do any work at all (Participant 7).*

The above statements suggest that failure to function occupationally is indicative of mental illness. Someone who may have previously managed his life well, may suddenly begin to have difficulties that may also include inability to work effectively.

Subtheme 5: Falling (*kupunzika*)

Failure to maintain balance appears to be one of the signs of mental illness. Someone with mental illness may lose their balance, resulting in repeated falls. They may fail to maintain the balance whilst sitting or standing. The following verbatim expressions illustrate this point:

> *An individual falls (Participant 8).*
>
> *You would find a person with mental illness suddenly failing to sit still or to stand still resulting in repeated falls (Participant 2).*

What is suggested above is that failure to maintain a sense of balance is one of the factors that need to be considered when the diagnosis of mental illness is considered.

Subtheme 6: Mutism (*kunyararisa*)

The participants pointed out that mentally ill people may suddenly become unresponsive to spoken words and may become mute. This mutism is attributable to some spiritual force that will prevent such a person from talking. The quotations below are an illustration of this:

> *A person may all of a sudden stop talking and become quiet. You will try to engage such a person, but they will not respond. That is when you should start suspecting that the person may be mentally ill (Participant 8).*
>
> *In the case of a child, he/she may start saying that he/she sees a chikiti (cat). When you look around, you may not see what the child is seeing. This will suggest that the child has been attacked by goblins (zvishiri). After such an attack, the child will stop talking and will remain mute (Participant 1).*

What the above quotations suggest is that mutism is one of those signs that will indicate to a traditional healer that a client is mentally ill. Some external forces like goblins are perceived to be the causal factors associated with mental illness.

Subtheme 7: **Increased or irregular heart beat (*kurohwa nehana*)**

According to some of the participants, increased or irregular heart beat is associated with mental illness. A mentally ill person may have difficulties with their heart beat. The following extracts illustrate this:

> *One will experience an increased heartbeat (Participant 7).*
>
> *This person will be experiencing a heartbeat as if he or she has been running (Participant 5).*

What the above quotations suggest is that an increased or irregular heart beat is understood to be one of the signs to look out for when the diagnosis of mental illness is to be considered.

Subtheme 8: Headache (*kutemwa nemusoro*)

The findings of the present study suggest that a severe headache is often associated with mental illness. The quotations below illustrate the way headache is understood and explained by the participants:

> *The cause of mental illness which is dangerous is when you blow medicine and say what you want to happen. You will have specified how you want an individual to be affected. This will cause dizziness or a headache in the victim as it begins to affect them (Participant 9).*
>
> *The affected person will complain of severe headache (Participant*
>
> *2).*

A headache will indicate to a traditional healer that there is a possibility of mental illness in his/her client.

Subtheme 9: Dizziness (*dzungu*)

The participants reported that mentally ill people experience a feeling of dizziness. The following verbatim expressions illustrate the theme of dizziness as observed by Shona traditional healers:

> *An individual will experiences dizziness which marks the beginning of severe mental illness (Participant, 9).*
>
> *As time passes, it will feel as if you are getting dizzy. If you realise that you are getting dizzy, then that is the end. You have now become mentally disturbed (Participant 1).*

As can be seen from the above extracts, dizziness is one of the signs of mental illness.

Subtheme 10: Perceptual disturbance

Perceptual disturbance was identified by the participants to be one of the indications of mental illness. One such form of perceptual disturbance is tactile perceptual disturbance (*kufambwa fambwa*) as illustrated in the extracts below:

> *Right! What makes the brain to lose normality is that when you are sitting like this, you may feel as if there is something moving in your head. This may prompt you to start scratching yourself even though there is actually nothing moving (Participant, 4).*

What the above extract suggest is that unusual perceptual experiences such as tactile disturbances are considered to be valid indicators of mental illness.

5.2.2 Theme 2: Causes of mental illness

Whilst mental illness is understood to be caused by both internal and external factors, there seems to be a strong view that the external factors (and in most cases, some spiritual forces) play a bigger role. This is evident in a number of cases, including accidents that are at times attributable to some spiritual forces that could be at play.

Subtheme 1: Witchcraft (*huroyi*)

It does appear from the findings of this study that some community members may have some evil intentions to the extent that they may want to harm others. Such evil intentions may be due to envy or jealousy. The participants gave accounts of the different deeds that are associated with witchcraft. Some of these deeds are outlined here below.

a). Goblins *(chikwambo/zvishiri):* The participants believed that some individuals with evil intentions may manipulate animal-like creatures to attack those that they intent to harm. The quotations below illustrate this:

There are animal-like creatures that can be sent by these people with evil intentions to harm others. They do have goblins (zvikwambo). They can send these creature to attack others (Participant 4).

Creatures may be sent to you. You may not see them, but they will fight you. You may end up falling down to the ground. These creatures will be looking like cats, birds and other animals (Participant 8).

As can be seen from the above extracts, the participants are of the view that some members of the community are driven by evil intentions to the extent that they can manipulate some animal-like creatures that may be sent to harm others.

b). Jealousy *(godo)*: According to the participants, some members of the community may be so envious or jealous that they may cause harm to others through witchcraft. This is illustrated in the extracts below:

Someone may ask you for some money, maybe $5 while sitting next to you. The person may feel so upset when you tell them you do not have the money (Participant 1).

It is usually a relative who may manipulate evil forces to cause you mental illness because of envy or jealousy (Participant 5).

What is suggested above is that jealousy may fuel others to act in such a way that may result in mental illness affecting those that they envy. It does appear that jealous relatives are the ones that are more likely to act in this malevolent ways.

c). Setting a trap *(kuteya)*: In some cases, someone with evil intentions may set some kind of trap *(kuteya)* by stealing and secretly placing the clothes of the person they want to harm in an ant-hill that has lots of termites. It is believed that the movement of the termites over the clothes will result in the targeted individual becoming mentally ill. The quotations below do reflect this belief by some of the participants:

You can go to any anti-hill and carefully break it into half. There are termites, usually during this time they will be rebuilding … You will end up being mentally ill, unless you get someone who knows about how to deal with this (Participant 7).

You can break an anti-hill into two halves and place the clothing of the person you intend to harm there. As the termites move up and down and they build their nest, they will affect the mental well-being of the targeted person. As the termites keep on moving, the targeted person becomes mentally ill or loses sanity again …. The person will not be able to control him/herself or even go to work (Participant 4).

What the above extracts suggest is that some people have the powers to manipulate living and non-living forces in the universe to cause harm to others. It is believed that through such actions that are brought about by evil intentions, the targeted person may end up being mentally ill.

d). Frog *(datya)*: Excretions of some animals are believed to have the potency to lead to mental illness. For example, the milk-like excretions derived from some small frogs are believed to have such powers. Those with evil intentions may poke such animals to excrete this substance which would then result in the targeted individual becoming mentally ill. The extracts below illustrate this:

Some milk-like substance will be excreted when you touch or poke some of the small frogs. When the small frog excretes such milk-like substance, you may become mentally disturbed (Participant 1).

The above extract suggests that some individuals are prepared to go to the extremes to cause harm. Forces external to an individual (such as excretions of an animal) are believed to have the ability to cause mental illness in someone who may be a distance away.

e). Charm (*kuromba*): Two participants pointed out that someone in the community may use some luck charms in order to achieve some success or to become rich. The participants indicated that a spirit of a dead person can be taken from the cemetery and controlled by an evil person. This spirit of a dead person or that of a living person will be in the form of an animal or item. If the rules of the charm are broken the evil person will have mental illness. The living person will be already mentally ill. This is shown in the following extracts:

> *An individual will take a charm because he/she wants to use it or is envious of someone's life. The spirit of a dead person who was rich is taken from the cemetery. The owner can choose to have either lucky stick, frog or snake. This will draw money from other people without them realising it. If it is a snake or frog, it will be vomiting money. It will be fed with milk. Some of the strict rules might be that the individual will not marry. If any of these rules are broken then the individual might have mental illness (Participant 2).*

> *An uncle can use a living child's spirit to form a charm with the help of a traditional leader which will result in the child having mental illness. As long as this child is mentally ill the uncle will be making a lot of money. This uncle will be taking care of the child by buying clothes and providing other things. However the uncle will never have him treated even though he can afford. (Participant 4).*

The above extracts suggest that people are willing to harness the spirit of the dead or manipulate the spirit of the living in order to be rich. It is believed that manipulation of the spirit of the living leads to mental illness while any deviations from the rules when harnessing the spirit of a dead person may result in mental illness.

Subtheme 2: Avenging spirits (*ngozi*)

It does appear that when someone is wronged whilst still alive, they may later come back as spiritual forces after death to seek compensation from those that wronged them.

a). A mother's avenging spirit (*ngozi yaamai*): Within the cultural context of the participants, it does appear that a mother in the family is such an important figure that should not be humiliated or abused. The belief is that when a mother dies, her spirit will come demanding for compensation from the child who wronged her. This is illustrated in the extracts below:

> *Let us say that your father has used your mother's cattle and you do not know about that. After the death of your mother, the used cattle may behave strangely in your life or your daughter's life may be affected by causing mental illness. Also another reason is, if you fail to give a cow to the mother-in-law for mothering your wife. When she dies her spirit will lead to mental illness in you or your children's lives (Participant 2).*
>
> *If you beat or insult your mother, when the mother dies her spirit may come to haunt you or your child, and this may result in mental illness (Participant 7).*

What the above extracts suggest is that a mother figure needs to be respected and treated well to avoid the possibility of being haunted by her spirit later in life. In other words, the belief here is that the spirit of the deceased has the power to come back and influence the lives of those remaining behind.

b). Avenging spirit of a stranger (*ngozi yemutorwa*): The participants indicated that an individual could experience mental illness because they or their relative may have wronged an outsider. After death, the spirit of such an outsider may come back and demand compensation from the individual or their relatives. The following verbatim expressions illustrate this:

If you need so and so to have (ngozi) revenge activated for a wrong they committed against you but which was not resolved. You will go to the cemetery and take the beads, necklaces or even anything placed on the grave, then bring them to a traditional healer who will give you instructions on how to use them. Once you are done following the instructions the person who wronged you will have mental illness (Participant 1).

The spirit of a wronged person who died might come to the killer or relatives of the killer saying, "Why did you kill me?" The relatives may not even know who killed the person. This spirit of the dead person's revenge will result in mental illness in the killer or his relatives (Participant 10).

From the above extracts, it can be suggested that the participants believe that the spirits of other people have the potential to harm others to the extent that this may result in mental illness.

c). Failing to appease the ancestors (*kusaitira mudzimu zvaunoda*): According to the participants, ancestors need to be appeased on a regular basis. In other words, the ancestors have the capacity to negatively affect the well-being of the living if they are ignored. For example, failing to perform a traditional ceremony may lead to ancestral wrath that may result in mental illness for the offending individual or their relatives. The extracts below illustrate this:

Ancestors protect us from any dangers. An evil person will make an assessment (kuvheneka), even using bones (hakata) to discover what a targeted person's ancestors want which the person did not do for them. The ancestors might tell the evil person that they needed a cow or ox for the household (mombe yemusha) from the target person. The evil person will kindly say that he/she can be able to give the ancestors the live beast. But he/she wants to either kill or cause mental illness in their child (target person). He/she will conduct a traditional ceremony during which the ancestors are given the beast. Then the ancestors will say to the evil person, "You have

given us the beast. We told our child that we need you to do this and then he refused. We said brew some beer for us and he refused." So now the evil person will brew the bear and all goes as he/she wants, which results in the target person becoming mentally ill (Participant 5).

Failing to conduct a traditional ceremony as requested by the ancestors may lead to their anger. The ancestors may make you or your children to develop mental illness (Participant 2).

What the above extracts suggest is that the ancestors are believed to continue to have a great impact on the lives of others. Constant contact and maintenance of good relations with the ancestors is thus perceived as important for the well-being of the living. Failure to maintain the good and health relations with the ancestors may result in mental ill health.

Subtheme 3: Head trauma (*kusangana kweropa nehuropi*)

Injury to the head is perceived by the participants as one of the causes of mental illness as reflected in the extracts below:

There are also other types of mental illnesses that are caused by accidents. Maybe something goes wrong in the brain as a result of head trauma and the person may end up with mental illness (Participant 2).

Head trauma may also result in mental illness. We also know that if a person has been involved in an accident, he or she may have brain damage as a result of the brain tissue mixing with blood. This may result in mental illness (Participant 9).

It does appear from the above extracts that there is some convergence between traditional African and the biomedical perspectives on what is seen as the causes of mental illness.

Subtheme 4: Theft (*kuba*)

Stealing other people's properties or goods was found to be one of the actions that may result in the offending individual becoming mentally ill. In the cultural context of the participants, it is believed that the offending individual's piece of clothing or footprints may be harvested from where the theft took place and concocted with some herbs. This kind of action is believed to have the potential to cause mental illness on the part of the offending individual. The following extracts illustrate this:

> *If something has been stolen from here, a traditional healer will sweep the floor and harvest the traces of the offending individual. Such traces could include footprints of the offending individual. The collected traces will be mixed with medicine and the offending person who stole the goods or property will become mentally ill (Participant 1).*
>
> *If someone steals a chicken from me, I can make the person to suffer. For example, I can make the chicken to make sounds in the offending person's stomach (Participant 5).*

What the above extracts suggest is that traditional healers are believed to have the powers to perform certain acts that may result in the offending person becoming mentally ill.

Subtheme 5: Bad spirits which follow spirit medium (*mweya yakaipa inotevera mudzimu*)

Participants reported that an individual can experience mental illness before initiation into being a traditional healer when there are bad spirits following the ancestral spirit. The evil spirit will be trying to shadow the ancestral spirit which results in an individual presenting with mental illness. The following verbatim expressions illustrate how the theme was observed by participants:

> *In the presence of an ancestral spirit there are bad spirits which follow it. These bad spirits causes mental illness in a person (Participant 10).*

There are spirits which follow the ancestral spirits before someone is initiated to be a traditional healer. Some people say that the ancestral spirit cause mental illness, but the ancestral spirit does not cause mental illness. What makes a person to be mentally ill is the spirit which follow the ancestral spirit before initiation into being a traditional healer (Participant 1).

From the above extracts, it can be suggested that some form of mental illness are viewed as interrupting the invitation by ancestors to be a traditional healer. By seeking the attention of a traditional healer to address the problem, the affected person's mental illness will subside. In other words, help from the traditional healer prevents the hindering evil spirit by empowering the person who will end up becoming a link between the ancestors and the living.

Subtheme 6: Love portion (*mupfuhwira*)

There were differing opinions by the participants as to whether or not love portions can result in mental illness. Whilst some participants perceived love portions as the possible causes of mental illness, others were of the view that these items can negatively affect social functioning. The quotations below illustrate this:

If a wife gives her husband an overdose of the love portion, the husband may end up becoming dull. In such a situation the husband will just fall asleep whenever the wife is close by. This husband might be left in the house while the wife goes out with a boyfriend. This kind of love portion is not good as the husband's social functioning is affected. The husband would have been made stupid, and he will agree with whatever instructions which the wife gives. (Participant 7).

The love portion which one ask from someone who is not his/her mother or mother-in-law is not good as it will cause mental illness or death. This happens when the one who gave you is not happy with your happy marriage life. Sometimes the relatives of the partner have never used medicine (mushonga). Then giving such a person the love portion which is taken

through bathing is very dangerous in causing mental illness. At times it might change someone to be a python (shato) (Participant 5).

It does appear from the above extracts that love portions have the potential to cause mental illness or to negatively affect the social function in a marriage.

Subtheme 7: Heredity (*chirwere chemhuri*)

Heredity was identified by the participants as one of the possible causes of mental illness. In this case, mental illness is perceived to run in the family. The following verbatim expressions illustrate this:

If my family of origin has mental illness, it is likely that someone in my family will have mental problems (Participant 3).

There are situations where one is born mentally ill. You will be told that this person was born like this. What this means is that the illness has existed even when the person was still in the mother's womb (Participant 6).

As was the case with head trauma, the issue of heredity seems to be a point of convergence between traditional African and the biomedical perspectives on what is understood to be one of the possible causes of mental illness.

5.2.3 Theme 3: Diagnosis and treatment of mental illness

The excerpts from the participants' narratives revealed that there are various ways of diagnosing and treating mental illness. In the process, a spiritual force is engaged to bring a narrative of the problem or to tell the medicine to be used.

Subtheme 1: Diagnosis (*kubata chirwere*)

Participants revealed that *kushopera* (divination), *girazi* (looking glass) and *kurotswa* (using dreams) can be used to provide a narrative which determines the cause and presence of mental illness.

a). Divination *(kushopera*): The participants believed that they could determine mental illness and its causes using the narrative from the spirit speaking through them or getting the narrative from the bones. In all the ways the ancestral spirit is used directly or indirectly to explore the problem. This was illustrated in the extracts below:

> *This gives the narrative explaining the cause of the mental illness, the diagnosis, and the medication which is needed and how it must be used. All the reasons for consultation and the goal will come out in divination (Participant 4).*

> *In helping people I use divination through an ancestral spirit. This means I have an ancestral spirit (mudzimu) which come and talk through me. It will explain what is happening by revealing the presence or absence of mental illness and the cause (Participant 7).*

The extracts above show that divination gives the traditional healer the ability to determine and explain mental illness and its causes. A spiritual power provides the narrative which will help to direct the treatment.

b). Looking glass *(girazi)*: According to the participants, a looking glass can be a medium between the ancestors and the traditional healer. The looking glass acts as an assessment instrument to see what is happening with a client. This is shown in the following verbatim expressions:

I use the looking glass to show what is exactly happening. An example is that the looking glass will tell if one has mental illness and what has caused it. If it is the mother's avenging spirits for the humiliation she suffered the looking glass will show the narrative. The instructions on how to treat the mental illness and the medicine is also given here (Participant 4).

This kind of projective method helps the traditional healer to examine the patient without touching him/her. It helps traditional healers to work within their ethical guidelines. What the above suggests is that the work of traditional healers is not guess work but is based on some form of assessment that helps in diagnosing people while avoiding violating the ancestral spirits.

c). Use of dreams *(kurotswa)*: The excerpts from the participants' narratives revealed that they diagnose and treat mental illness using the instructions that they will have received during their dreams. The participants believe that through the dreams, they interact with the ancestors who will show them the people that will come to consult. Furthermore, through these dreams, the problem of the client including how it should be treated is revealed to the traditional healer. The quotations below illustrate the sentiments by the participants:

Some of these things do differ because the medicine should come from the ancestors. I cannot just take a hoe to go and dig the roots of the medicine. I would have seen the medicine and the client's problems in my dreams. I would also have been told how to use the medicines including the kinds of conditions that these medicines treat. Some traditional healers who use water in performing their work will see the water in their dreams. The water will also be containing the kinds of medicines that will be suitable for their clients (Participant 1).

I will have dreams about a person who is coming with a condition which I have never treated before. I will be shown the tree from which I need to extract roots or barks or parasites that will be used as medicine for my clients. These dreams will be in the form of commands that instruct me to go and get the medicines from a particular place. When I wake up from my sleep, I would be expected to go to and get the medicine from the place that was shown in my dreams. If you try to ignore the dream and sleep again, you will be woken up until you undertake the trip to go and get the medicines from the designated place that was shown to you in your dreams. (Participant 4).

The extracts above show that spiritual powers from the ancestors are accessed by the participants through dream. This is how they also learn about some new conditions, that they may be expected to treat. Furthermore, through these dreams, the participants are able to be guided by the ancestral spirits on how to prepare and administer the medicine to their clients. It is spiritual connection which is perceived by the participants to be making their dreams sacred and a medium through which they can diagnose and treat mental illness.

Subtheme 2: Treatment methods (*nzira dzekurapa chirwere*)

From the results of the present study, it does appear that the participants understand the treatment that they give to their clients to be informed by the diagnostic methods that they use. A number of procedures that involve the use of various items such as, animal and plant parts extracts were found to be used as illustrated below:

a). Use of medicine *(mushonga)*: All the participants did indicate that they make use of medicines to treat mental illness. Such medicines were concocted from a wide range of items that include animal and plant extracts. According to the participants, some of these medicines are edible whilst others are not. The medicines identified by the participants include *njuzu yemukosvi, pfuta* and *mushonga wekuchaisa* (cultural laxative). The participants believe that the spiritual powers that guide them in their work help them to make the right choices of the specific medicines that they need to use for specific problems. Some examples of medicine are expressed below:

Example1: The use of *njuzu yemukosvi*: Some of the participants reported that they treat mental illness using *njuzu yemukosvi* which is a parasitic plant growing on another tree. According to the participants, it is used to assess if a bad spirit had inflicted serious damage to a client, and this plant helps to remove the spirits. Though different parts of this particular plant can be used, the roots are believed to be more effective as reflected in the following extracts:

> *The tree from which the branches that are used to roof thatched huts in the rural areas is called mukosvi. It is on this tree that the parasitic tree (gomarara/njuzu) grows. In other words this parasitic tree grows on other trees. The parasite are trees which grow on another tree. This is the plant we use in treating mental illness (Participant 2).*
>
> *Even though you can still use the other parts of the mukosvi plant as medicine, the most effective parts are the roots. Drinking the medicine from njuzu yemukosvi will cause you to vomit. The medicine also has the power to remove spirits in the stomach. After the spirit has been removed the person will be mentally well and those who could not conceive may be able to do so and give birth (Participant 5).*

As can be seen from the above extracts, *njuzu yemukosvi* is interpreted by the participants to be one of the plants that has the power to help in the assessment and treatment of mental illness. The plant is also believed to have the potency to help remove the spirits that may reside in a person's stomach. This suggest that the plant has some spiritual effect in addition to its medicinal power to treat mental illness.

Example 2: Laxative (*mushonga wekuchaisa*): Some participants suggested that there are some African traditional laxatives that can be used to induce diarrhoea resulting in the amelioration of the mental illness symptoms. Such a laxative is believed to have the clinical effect of removing any bad spirit in the stomach of the mentally ill, which in turn, resolves their mental illness. This is illustrated in following verbatim expressions:

This is when you give someone a laxative (mushonga wekupanzisa) which is aimed at removing all the dirt in the stomach. So this is consumed to clear other things such as ulcers and to remove spirits in the stomach which cause mental illness (Participant 2).

You need to induce diarrhoea in the person with mental illness. Use the laxative which will remove the smoke (hutsi) in no time. For you to tell that the person has been healed they will pass out dark faeces like tsvubvu. The mental illness will be treated (Participant 5).

The above extracts suggest that a laxative that is given to the individual with mental illness has the power to remove the physical manifestations and the spiritual impurities that are understood to be located in the stomach. Consequently, a person who has been effectively treated for mental illness with the laxative will pass dark faeces that are suggestive of a favourable prognosis.

Example 3: Ways of administering medicine *(nzira dzekupa mushonga)*: Based on the statements of the participants, it does appear that there are many ways to administer medicines that are aimed at treating mental illness. One of the common methods is oral administration of the medicine. It was also found that the client is expected to engage in some recitals whilst taking the medicines. This is demonstrated in the extracts below:

Some of the medicine (mushonga) is taken orally. For example, i will take the roots of njuzu yemukosvi and grind them into some powder. The powder will then be mixed with water and maize meal to prepare soft porridge. The soft porridge will be given to the mentally ill person to eat whilst at the same time saying something like: 'If there is anyone who has bewitched me, let this illness revert to him.' Such recitals that are made whilst taking the medicines have the power to throw the mental illness back at the person who will have brought it to the client. Apart from oral administration, medicines may also be taken through bathing and by lacerations (kutemera) on the client's skin (Participant 1).

There are some bad spirits that cling to the person with mental illness like dirt. The medicines that we give to such a client to wash these bad spirits in the same way that you use water to wash dirt on the body. So we want the evil spirits to be removed when we bath with medicine. These evil spirits do not like certain smells. So, the medicine that the person with mental illness baths with, will help to rub off the evil spirits (Participant 6).

From the above extracts, it does appear that the participants are convinced that certain actions by nefarious people and some external forces may bring about mental illness. The administration of medicines, which is done in conjunction with some rituals by a client, helps to treat mental illness. The implication here is that the medicine alone cannot remove what is seen as mental illness. Instead, the medicines are believed to be effective only when they are accompanied by some other religiously inspired and culturally meaningful activities like the recitals and the bath waters that can wash the dirt. What the above extracts suggest is that mental illness is conceptualised as something that attaches itself to the human body like dirt which can be removed through a bath.

Example 4: Giving assurance about the safety of the treatment *(chivimbiso chekuti mishonga haikuvadze)*: Some participants emphasised the importance of assuring their clients about the safety of the treatment that they provide. For example, before administering the medicine, a traditional healer is expected to administer a bit of this on himself/herself in full view of his/her client before advising the client to take the treatment. This is believed to demonstrate to the client that the medicine is safe. The following extracts illustrate this:

You have to taste all the medicine which you will use. You must take the medicine yourself to see what happens. You can only administer the medicine on others after checking it yourself. This will help you to determine the dose that should be administered (Participant 3).

There is medication which is taken with soft porridge. The patient will be expected to take this medicine using a piece of reed, and not with his/her hands. After eating the medicated soft porridge, the client will be advised to go to the nearest river to throw away the piece of reed so that it can be washed away. This is to be done as the water in the river makes the noise that goes hwa hwa hwa hwa, and throw the reed (Participant 8).

It does appear from the above extracts that safety of the medicines is a very important element that is considered by traditional healers when medicine is administered. By going as far as having to taste the medicine himself/herself, the traditional healer gives the client the assurance that the medicine is safe. This particular action by the traditional does probably have the potential to encourage treatment adherence which may translate into some therapeutic gains. The above extracts also demonstrate the symbolic value attached to the forces of nature in enhancing good mental health. As illustrated in the last extract above, it is as if the client's mental illness is transferred onto the piece reed which, when disposed, is almost tantamount to disposal of the mental illness itself.

Example 5: Enhancing treatment *(kurerutsa basa)*: The excerpts from the participants' narratives revealed that the treatment of mental illness can be enhanced by using a specific insect called *pfuta* which is mixed with medicine. When this is applied by a traditional healer, they believe that their work will be easier. The quotations below illustrate this:

You need to use fat extract from the insect called pfuta. The fat extracts are mixed with other medicines and applied on the traditional healer's body. Once that has been done things will be fine (Participant 5).

What the above extract suggests is that some extracts from insects have some healing powers when mixed with other medicines. The suggestion here is that a combination of medicinal items, and not only one item, lead to positive treatment outcomes in those suffering from mental illness.

Subtheme 3: Dealing with bad spirits (*kubvisa mweya yakaipa*)

It does appear from the findings of the study that spiritual forces play a very important role as one of the causal factors in mental illness. . Most of these spiritual forces that have the potential to cause mental illness appear to be negative and detrimental as reflected in the subthemes presented below:

a). Pushing away bad spirit (*kusudurudza mhepo*): The excerpts from the participants' narratives suggest that people commit mistakes that have the potential to invite evil spirits that can cause mental illness. In such instances, a domesticated animal may be used to help in the treatment of the client as reflected in the excerpts below:

> *At times we unconsciously do wrong things that can bring us evil spirits that cause us mental illness. In such cases, you need to acknowledge that you might have done wrong. The way to deal with the evil spirits that are brought about in this way is to use a domesticated animal. In this case, we would cast the evil spirits onto the animal which would wander away. In so doing, the animal will carry away the evil spirits and the mental illness (Participant 1)*
>
> *There are times when we do wrong unknowingly and we need to use a domestic animal to help in removing the mental illness from a client. In life people are aware of their wrong doings and at times they are not. Traditional healers have the power to help us deal with mental illness with varying causes (Participant 9).*

What is suggested in the above extracts is that our unconscious actions have the potential to cause us mental illness. It is believed that mental illness that is as a result of such actions can be treated through the use of a domestic animal. The illness is understood to be symbolically transferred onto the domestic animal which will carry away the illness into the woods.

b). Re-directing the evil spirits to afflict a wrong doer *(kudzosera mweya wakaipa kune akawutumira*): According to some participants, it is possible that an evil spirit may wrongfully descend on someone who may not have been the intended recipient. It is believed that traditional healers have the power to redirect such evil spirits to those who are, as a result of their wrongdoing, supposed to be afflicted by such evil spirits. The following verbatim expressions illustrate this:

> *A person can only pay for a wrong which he/she has done. In cases where a person is paying for the wrong deeds of someone else, we can redirect the evil spirit to the offender (Participant 2).*
>
> *If you have been wrongfully cast with an evil spirit, we will give you medicines to use when bathing. In addition to this, the traditional healer will cause the evil spirit to be transferred to the offender. To do this, we use extracts of different trees and roots that are extracted from the woods (Participant 10).*

The above extracts suggest that what is considered as mental illness in the cultural context of the participants can be transferrable in the sense that a traditional healer has the ability to cause the illness to be transferred from someone who is wrongfully afflicted to a wrong doer.

c). Inducing the spirit to talk *(kudhonza mhepo kuti itaure):* In some cases, it does appear that a traditional healer may be required to induce a spirit that has caused mental illness in a client to reveal itself and to talk. In situations like that, a traditional healer will prepare and administer to a client some medicines that will get the evil spirit to reveal its intentions. This is illustrated here below:

> *We use extracts from some trees and roots. We mix these and use such a concoction to invite the spirit to engage with us in conversation. Through this conversation the spirit will reveal what the preconditions will be for it to move out of the client (Participant 7).*

What the above extract suggest is that a traditional healer is understood to be having some transcendental powers that enable him/her to engage the spiritual forces whilst at the same time maintaining contact with the living. In other words, the medicines used, together with the spiritual connections, help a traditional healer to manage the mental illness that a client presents with.

Subtheme 4: Compensation (*kuripa*)

According to the participants every wrong done by a family member should be corrected to avoid the possibility of such actions bringing mental illness to the family. Such corrective actions will help in maintaining good mental health. The extracts below illustrate this:

> *Someone who ill-treats his/her mother may through such actions invite some evil spirits that may cause mental illness. At times, such wrong actions may result in mysterious accidents or illnesses attacking your children. When you consult, you may be told that there are some spirits aggrieved by your wrong actions. As a traditional healer you need to advise such a person to engage in some activities that will help to correct the wrong and in the process restore good mental health to the client and the family (Participant 1).*

> *The proper treatment to deal with an avenging spirit is to make amends as required. The other way is to send back the avenging spirit to the rightful person who wronged it. But you will not compensate an avenging spirit which you did nothing wrong to (Participant 10).*

The above extract suggests that good social behaviour leads to good mental health. Respect for one's parent is considered a very important ingredient that helps to maintain good mental health for individuals and their families.

5.2.4 Theme 4: Challenges faced by traditional healers

Like other professions, traditional healing appears to have some challenges that those practising the profession need to be mindful of. Among others, the challenges include treatment failure, a traditional healer's emotional states such as anger, and jealousy.

Subtheme 1: Treatment failure (*mushonga unotadza kurapa*)

Some of the participants did acknowledge that certain interventions may work with some but not all their clients. For example, a client may not respond positively to exactly the same medicine that a traditional healer may have used successfully with another client with a similar problem. This is illustrated in the following extracts:

> *The medicine that we give to clients does work at times to treat a variety of conditions. However, some clients may not respond positively to the same medicine that may have been effective to treat another client with a similar condition. The same person who might not have responded positively to my medicines may go to the next practitioner. Upon receiving medicine from another traditional healer, such a client might get better even though the medicines from the alternative traditional healer may not be as powerful as the medicines that I will have given to the client (Participant 1).*

> *The medicine that you might have given to the patient might not be getting to the blood well. Some of the medicine might be failing or refusing to be absorbed into the client's blood stream. So at the end it might be as if the medicine has been ineffective (Participant 5).*

What the above extracts suggest is that the participants do acknowledge that there are some limitations in terms of their interventions. They do admit that some clients who do not respond positively to their treatment may need to consult elsewhere. What is also emerging from the above extracts is that the participants are at times unable to explain why some interventions are effective with one particular client

whilst failing to bring the same positive effect to another client presenting with a similar problem.

Subtheme 2: Anger (*kutsamwa*)

The excerpts from the participants' narratives suggest that a traditional healer cannot be effective if they are emotionally troubled. In other words, emotions like anger as illustrated in the following extract can negatively affect the effectiveness of a traditional healer. The extracts below illustrate this:

> *There are other things such as anger that can affect your work. It will make it difficult for you to go and fetch some medicine from the bush (Participant 4).*

What is suggested above is that a traditional healer's effectiveness is adversely affected if he/she has some negative emotional feelings like anger. What is implied here is that this kind of work requires constant interactions with clients and the spiritual world calls for emotional stability.

Subtheme 3: Jealous (*godo*)

Two participants did suggest that their effectiveness as traditional healers may be negatively affected by their own relatives who may be jealous. The extracts below illustrate this:

> *Relatives may envy the benefits which you get from being a traditional healer. Once they start asking for some of the money which you get from clients, they might never stop asking. If you fail to give them one day, it will make them angry. They will use medicine to treat your place so that sick people will no-longer come to consult (Participant 4).*

Relatives who are unhappy with a traditional healer's benefits can speak to the spirit medium to block it (kuutsindikira kana kutsipika). They will manage to do this by shouting (kupopotera) at the spirit medium in a wooden plate. Once they close the plate, the traditional healer will no-longer be successful in his work (Participant 6).

The above extract suggests that some relatives can be motivated by evil intentions to the extent of harming the work of traditional healers. Such evil intentions and actions by others may interrupt the connection that has been established between a traditional healer and the ancestral beings. The implication here is that a traditional healer can only be effective if he/she is forever having constant interaction with the ancestors as these spiritual forces are believed to provide the necessary guidance.

Subtheme 4: Concerns by traditional healers around theft of ideas and intellectual property (*kuba*)

Some of the participants did raise concerns about those who steal their ideas. In other words, the participants felt that they are being used by other professionals who interact with them with a view to stealing their ideas. The quotations below illustrates this:

At times we share information on how we treat mental illness with others. These people will then use this information that we have given them to make themselves popular at our expense. They will behave as if the information that they have obtained from us is theirs (Participant 1).

When I tell the western trained colleagues about the medicines that I use, they will want to know the name of tree from where the medicine was extracted. Once they know the tree, they take it to be their own and will no-longer recognise me as the person who gave them the information. They want to make money alone (Participant 8).

What the above extracts suggest is that there participants do not trust others who might want to understand their methods of healing. This situation is caused by what the traditional healers perceive as a greedy tendency by others to steal and use their knowledge. This finding brings into focus the legal issue of intellectual property vis-à-vis indigenous knowledge systems.

Subtheme 5: Discrimination (*rusarura*)

Participants reported that they feel discriminated by the authorities and churches who view their practice as unscientific and evil. It was further pointed out that some members of the community are of the view that nothing good comes from traditional healing. The following extracts illustrate this:

> *Some members of the community and the authorities do not understand how we treat people. For example, I am not allowed by the authorities to travel freely carrying my medicines. I have to always say to them I am carrying some supplements whenever they stop and search me. Once I say this is a drug I will have a big problem with the authorities who want to control and test my drug (Participant 3).*
>
> *Because some community members go to church every Sunday and they are told not to visit traditional practitioners because our practices are painted as evil. It is like we are fighting a war using catapults whilst the opposition is allowed to use guns (Participant 8).*

The above extracts suggest that the participants feel that they are not accepted by authorities, the churches and some community members. There appears to be a deliberate effort by those in authority to diminish the role and value of traditional healing. It is this kind of negative attitude that is likely to hinder efforts that are aimed at encouraging collaboration between western trained health practitioners and traditional healers.

Example 1: One way referral system (kusapihwawo varwere): Some of the participants felt that the current arrangement provides for a one-way referral system where a traditional healer is expected to refer clients to western trained health practitioners and not the other way round. This is illustrated in the quotations below:

> *The main barrier in collaborating with our western trained counterparts is this so-called referral system which in my view is only one way. In those cases where some western health practitioners may want to refer to us, they would do so privately. It is not something which is being done openly (Participant 4).*

> *The referral system is only one sided. They say if people come with conditions such as asthma, we should refer to the hospital. We are told not to stay with people with such conditions. Cancer and other mental illness can be treated by traditional healers and we need to be given referrals to treat them. We have become agents that only assist the hospital system to use their drugs and make money (Participant 9).*

As can be seen from the above extracts, the participants feel that they are not recognised and treated as equals when it comes to health care delivery. The power dynamics embedded in this kind of relationship between western and traditional healing systems seems to hamper prospects for meaningful dialogue between the two systems.

Example 2: Unfair assessment of the traditional healing system by the authorities (kusaongororwa zvakanaka): Participants reported that they feel that the authorities do not have adequate knowledge to assess and pass judgement on their system. These authorities use criteria developed for the biomedical system to judge and disqualify the traditional healing system. This is illustrated in the following extract:

> *We ask the authorities as to what it is that they want to investigate in our work. This is mainly because they have no clue about our healing system. Their Council and the researchers have been taught that the mainstream western health care is the only way. They do not understand our system of healing (Participant 4).*

What is suggested above is that the authorities do not seem to understand and embrace the epistemology that serves as a foundation for traditional healing. Instead, the authorities tend to use the western epistemological lens to judge and disqualify a system that requires a different approach to understand.

Example 3: The high costs for healthcare standards compliance (mari yekuti gwenzi revhenekwe): In order to test the drugs that they use, the traditional healers are expected by the authorities to pay some money to have these researcher test the medicine. The participants perceive this requirement as a hindrance due to the high cost involved as illustrated in the extract below:

> *There is a problem in drug control. We need our drugs to be controlled. In order to have our medicines tested, we are expected to pay an amount of $2 000 for each drug. Then I asked them: What do you want to investigate? This is mainly because no one has bothered to understand how our system works. Their Council and researchers have only been taught mainstream medicine. They do not know about our way of doing (Participant 7).*

The participants are of the view that the amounts being charged for them to comply with the healthcare standards that are premised on the western oriented system. They perceive the system that is meant to assess their drugs and to uphold healthcare standards as unfair to them.

5.2.5 Theme 5: Facilitating factors in the work of traditional healers

The participants who took part in the present study were of the view that there are certain enablers that help to promote their effectiveness. These include remuneration for work done and the opportunities that are provided for the traditional healers to teach each other.

Subtheme 1: Remuneration for the work done

Issues of honesty and fair remuneration for work rendered appeared to influence the work of traditional healing. The subthemes associated with this particular theme are outlined here below.

a). Honesty *(kuvimbika)*: The participants emphasised the ethical issue of honesty on their part and also on the part of their clients. They expressed a view about the need for the client to be honest and for them as practitioners to be equally honest. Honesty was understood to be helping clients to make informed decision regarding treatment. Some participants pointed out that they will only accept payment for treatment offered and completed. In the event where treatment is not completed, the client is entitled to receive a refund. The quotations below illustrate this:

> *What makes my job easier to do is honesty. If you are honest everything will go well. If I am going to charge $100, I will tell the client upfront that I need such an amount for the service rendered. I do not change the amount to be charged haphazardly. This gives the client the opportunity to make an informed decision based on whether or not they can afford the amount that I have charged (Participant 2).*

> *If there is a problem and things are not working or there is an argument. I will refund the client his/her consultation fee. In some cases I may consider giving back to the client a part of the consultation fee if I feel that I have partly provided some treatment. I will advise such a person to seek treatment for their condition elsewhere (Participant 3).*

Issues of honesty and fairness seem to be central in the traditional healer's dealings with the clients. This suggests that the traditional healers are guided by some ethical principles in their work. Such high ethical standards seem to translate into some positive therapeutic gains for the client.

b). Affordability for services rendered *(kubhadhara kusingaremere vanhu)*: It appears that the participants try hard to ensure that what they charge for their services is affordable for their clients. They seemed to put emphasis on flexibility with regard to payments. This was found to make the service offered by the traditional healer accessible and affordable. In addition, the participants seemed to put the interests of their clients first as illustrated by the following extracts below:

> *If there is no money I will still attend to the client. . I will then negotiate with the client to pay me using whatever is affordable for them. For example, if you come with a DVD player, or stove or even any other useful item, I will keep that as a promise to pay (Participant 3).*

> *If you do not have money at the time of your consultation, I may keep one of your valuable items like DVD player or stove as surety. I will then go ahead to provide treatment to the client. The client may later come to collect their valuable item when they have managed to raise the money owed to me (Participant 10).*

What is suggested above is that battering and other payment arrangements are negotiated with the clients before services are rendered. In this process, the interests of the client appear to be paramount to the traditional healer. This suggests that the traditional healer is primarily motivated by the need to improve the mental health of the clients than the associated financial gain.

Subtheme 2: Continuous professional development (*kudzidzisana*)

The excerpts from the participants' narratives suggest that they do value continuous professional development which is acquired mainly through some form of peer education. They feel that when those who have knowledge and experience in specific areas teach others, they all benefit. The quotations below illustrates this:

> *For our work to be smooth we teach each other. Those who know better in certain areas will be expected to teach others (Participant 10).*

> *What helps a lot is when someone who knows teaches others. You will all be benefiting (Participant 7).*

The above extract suggests that participants are amenable to learn from their peers in order to increase their knowledge and skills. The implication here is that the traditional healers have developed their own system of continuous professional development that is premised on some principles of sharing, trust and peer education.

5.3 Conceptualisation of associated illnesses by Shona speaking traditional healers

The table below summarises the findings in terms of the emerging themes and subthemes related to the conceptualisation of conditions that are not mental illness but could be closely associated with mental illness:

Table 3: Emerging themes and sub-themes in the conceptualisation and treatment of associated illnesses

THEME	SUB-THEMES
Theme1: Epilepsy (*Pfari)*	**Subtheme 1:** Characteristics of epilepsy (*pfari)* **Subtheme 2:** Causes of epilepsy (*pfari)* **Subtheme 3:** Treatment of Epilepsy (*pfari)*
Theme 2 : Sexual dysfunction (*Kusungwa)*	**Subtheme 1:** Types and characteristics of Sexual dysfunction *(kusungwa)* **Subtheme 2:** Other forms of sexual dysfunctions **Subtheme 3:** Causes of sexual dysfunctions **Subtheme 4:** Treatment of sexual dysfunctions

As can be seen from the above table, three categories of themes linked with the conceptualisation of associated illnesses were extracted from the data. The first category was types/characteristics of associated illnesses, the second was the causes of associated illnesses, and the third was treatment of associated illnesses.

The participants reported that there were some conditions that they consider to be closely associated with mental illness. In other words, people suffering from these associated conditions will show some significant distress that is displayed in cases of mental illness. The three associated conditions that were identified by the participants are *pfari* (epilepsy), *kusungwa* (locking) and *kuuraya nhengo* (sexual dysfunctions).

5.3.1 Theme 1: Epilepsy (*Pfari*)

Subtheme 1: Characteristics of epilepsy (*pfari*)

The participants attributed epilepsy to some forces that present themselves in the form of animals-like creatures that will be seen by the person suffering from this condition. The images of the animals are believed to result in some form of seizures or falls (*kupunzika*). These seizures are experienced as involuntary and disturbing to the affected individual and those around him/her as reflected in the following extracts:

> *Some animal-like creatures may be sent to you which other people will not see. These creatures will fight you. All of a sudden you will fall down to the ground. But before falling down, one may at times first see animal-like creatures such as cats, birds. A person will fall and shake. At times they will start drooling. (Participant 10)*
>
> *Some people have the falling sickness where they suddenly fall. (Participant 6)*

The above extracts give the impression that the participants do recognise the existence of a distressing condition known as *pfari* which, in Western medicine, could be likened to epilepsy. The person who has *pfari* shows signs and symptoms similar to those displayed by people suffering from epilepsy. These symptoms are understood to, among others, include: a). temporary confusion and formed visual hallucinations (for example, visions of animal-like creatures); b). Seizures resulting in non-purposeful movements; and, c). Drooling. Based on what is described above, it can be suggested that traditional healers do recognise the existence of a condition that is known as epilepsy in Western medicine. Though the two conditions (that is epilepsy and *pfari)* appear to be similar in terms of manifestation, it does however appear that culture determines how each of these conditions is understood and described. For example, whilst a Western trained health practitioner may perceive temporary confusion and formed visual hallucinations as symptoms associated with epilepsy, a traditional healer may describe similar experiences as visions of animal-like creatures that will fight the individual resulting in him/her falling down.

Subtheme 2: Causes of *pfari*

a). Witchcraft (*huroyi*): It does appear from the findings of this study that some community members may have some evil intentions to harm others, such evil intentions may be due to envy or jealousy. The participants gave accounts of the different deeds that are associated with witchcraft. Some of these deeds are outlined here below.

b). Goblins *(zvikwambo/zvishiri):* The participants believed that some individuals with evil intentions may manipulate animal-like creatures to attack those that they intent to harm. The quotations below illustrate this:

> *There are animal-like creatures that can be sent by these people with evil intentions to harm others. They do have goblins (zvikwambo). They can send these creature to attack others (Participant 4).*

Creatures may be sent to you. You may not see them, but they will fight you. You may end up fall down to the ground. These creatures will be looking like cats, birds and other animals (Participant 8).

As can be seen from the above extracts, the participants are of the view that some members of the community are driven by evil intentions to the extent that they can manipulate some animal-like creatures that may be sent to harm others.

c). Heredity *(chirwere chemhuri)*: Heredity was identified by the participants as one of the possible causes of associated illness. In this case, *pfari* is perceived to run in the family. The following verbatim expressions illustrate this:

If my family of origin has pfari, it is likely that someone in my family will have mental problems (Participant 3).

There are situations where one is born ill. You will be told that this person was born like this. What this means is that the illness has existed even when the person was still in the mother's womb (Participant 6).

As was the case with head trauma, the issue of heredity seems to be a point of convergence between traditional African and the biomedical perspectives on what is understood as one of the possible causes of *pfari*.

Subtheme 3: Treatment of epilepsy (*pfari)*

The findings of the study indicate that spiritual forces play a very important role as one of the causal factors in mental illness as well as associated illnesses. Most of these spiritual forces that have the potential to cause associated illness appear to be negative and detrimental as reflected in the subthemes presented below:

a). Pushing away bad spirit *(kusudurudza mhepo*): The excerpts from the participants' narratives suggest that people commit mistakes that have the potential to invite evil spirits that can cause associated illness. In such instances, a domesticated animal may be used to help in the treatment of the client as reflected in the excerpts below:

> *At times we unconsciously do wrong things that can bring us evil spirits that cause us pfari. In such cases, you need to acknowledge that you might have done wrong. The way to deal with the evil spirits that are brought about in this way is to use a domesticated animal. In this case, we would cast the evil spirits onto the animal which would wander away. In so doing, the animal will carry away the evil spirits and the pfari (Participant 1).*
>
> *There are times when we do wrong unknowingly and we need to use a domestic animal to help in removing pfari from a client. In life people are aware of their wrong doings and at times they are not. Traditional healers have the power to help us deal with pfari which has varying causes (Participant 9).*

What is suggested in the above extracts is that our unconscious actions have the potential to cause us *pfari*. It is believed that a mental illness that is a result of such actions can be treated through the use of a domestic animal. The illness is understood to be symbolically transferred onto the domestic animal which will carry away the illness into the woods.

b). Re-directing the evil spirits to afflict a wrong doer *(kudzosera mweya wakaipa kune akawutumira*): According to some participants, it is possible that an evil spirit may wrongfully descend on someone who may not have been the intended recipient. It is believed that traditional healers have the power to redirect such evil spirits to those who are, as a result of their wrongdoing, supposed to be afflicted by such evil spirits. The following verbatim expressions illustrate this:

A person can only pay for a wrong which he/she has done. In cases where a person is paying for the wrong deeds of someone else, we can redirect the evil spirit to the offender (Participant 2).

If you have been wrongfully cast with an evil spirit, we will give you medicines to use when bathing. In addition to this, the traditional healer will cause the evil spirit to be transferred to the offender. To do this, we use extracts of different trees and roots that are extracted from the woods (Participant 10).

The above extracts suggest that what is considered as *pfari* in the cultural context of the participants can be transferrable in the sense that a traditional healer has the ability to cause the illness to be transferred from someone who is wrongfully afflicted to a wrong doer.

c). Inducing the spirit to talk (*kudhonza mhepo kuti itaure*): In some cases, it does appear that a traditional healer may be required to induce a spirit that has caused *pfari* in a client to reveal itself and to talk. In situations like that, a traditional healer will prepare and administer to a client some medicines that will get the evil spirit to reveal its intentions. This is illustrated here below:

We use extracts from some trees and roots. We mix these and use such a concoction to invite the spirit to engage with us in conversation. Through this conversation the spirit will reveal what the preconditions will be for it to move out of the client (Participant 7).

What the above extract suggest is that a traditional healer is understood to be having some transcendental powers that enable him/her to engage the spiritual forces whilst at the same time maintaining contact with the living. In other words, the medicines used, together with the spiritual connections, help a traditional healer to manage the mental illness that a client presents with.

5.3.2 Theme 2: Sexual dysfunction (*Kusungwa*)

Subtheme 1: Types and characteristics/types of sexual dysfunctions (*kusungwa)*

As is commonly understood, sexual dysfunctions in Western medicine and psychology refer to those difficulties that an individual or a couple may experience during any stage of a normal sexual activity. Such difficulties may cause the affected individual not to experience any of the following: physical pleasure, sexual desire, arousal or orgasm. Participants in the present study did identify and describe a number of conditions that appear to parallel sexual dysfunctions as understood in Western medicine and psychology. The conditions identified by the participants included the following: *kufuratidzwa moyo* (losing sexual interest) and *kupindura nyoka yemudumbu* (infertility). The participants also identified another form of sexual dysfunction (known as *kusungwa*) which is understood to be self-induced. In this particular case, the individual will consult a traditional healer with the intention to have his/her sexual organ "locked". Some economic factors appear to be behind this kind of psychosexual dysfunction. What follows here below are the different types of psychosexual dysfunctions as understood and described by the participants.

a). Losing sexual interest *(kufuratidzwa moyo)*: The participants' narratives suggest that some people experience sexual problems that are characterised by the sudden loss of interest in sexual activities with a partner. In some extreme cases, an individual with such a problem may not want to see a person of the opposite sex. The quotations below illustrate the participants' views on this matter:

> *You just lose interest even in touching her. If you are with a woman, you lose interest. At this point your heart has no desire to engage her sexually. You will not suspect anything because you will think that you want to engage in some sexual activity with this woman. Unfortunately, before you do that, the desire and interest in her is lost (Participant, 10).*

A wife is affected spiritually by the husband so that she will not enjoy sex with any other man. When you have been locked you will not have the desire to have sexual intercourse. You may not even want to see women. The person might not want you to have a family (Participant, 1).

The above statements suggest that an individual's sexual desire may be diminished or lost when he/she gets closer to a person of the opposite sex. At the cognitive level, an individual so affected may want to initiate some sexual activity. However, the desire for such an activity may be diminished or lost, resulting in the sexual activity being aborted. It does appear from the above extracts that this condition may be caused by the evil intentions of those who might not want the affected individual to have a family.

b). Failure to experience or maintain an erection (*kutadza kumira kwenhengo yemurume)*: Failure to experience an erection or to maintain it was understood by the participants to be one of the sexual dysfunctions that leads to considerable distress in the individuals affected. In some cases, a man may only experience and maintain an erection when he is with his wife. The erection may be lost or not experienced at all when the man tries to engage in some sexual activity with another woman. This kind of selective erection is understood to be engineered by a spouse who may have the spiritual powers to cause such a temporary dysfunction. The extracts below illustrate this:

One can experience an erection. But when the lady undresses, he may be unable to maintain the erection. This will lead to his failure to penetrate. (Participant 1)

A husband can be affected by his wife spiritually so that he will only have an erection when he is with her. If such a man has an extra marital affair, he may not get an erection when he wants to engage in some sexual activity with another woman. In this case, the delinquent partner will not succeed in having sexual intercourse outside the marriage (Participant 4).

What is suggested above is that the participants do recognise the existence of what is commonly known as erectile insufficiency in Western medicine and psychology. According to the participants, an individual with *kutadza kumira kwenhengo yemurume* will fail to have an erection even though they may have a desire to engage in sexual intercourse. In some cases, the erection may be experienced temporarily, but only to be lost when the woman undresses. In both these situations, the affected individual will fail to have any form of sexual intercourse. From the above extracts, it does also appear that some women have spiritual powers to "lock" their husbands' sexual organs to an extent that the affected individual will fail to have or maintain an erection when they are trying to engage in sexual intercourse with another woman. What is suggested here is that actions by others who may even be a long distance away, have the capacity to cause erectile insufficiency in others.

c). Involuntary penis withdrawal (*kudzokera mukati kwenhengo yemurume*): Participants pointed out that, in some cases, a man may have the interest, desire and the erection to engage in sexual intercourse. As soon as such an individual tries to penetrate the woman, the penis will involuntarily withdraw. However, the erection may be restored as soon as the penis is ejected. The quotations below are an illustration of this:

> *The penis will withdraw inside like a tortoise when he penetrate the woman. Once the penis is withdrawn, the regain his erection (Participant 1).*
>
> *The penis will withdraw as it penetrates. It is not painful, it just disappears. The husband will be unable to penetrate any other woman who is not his wife (Participant 2).*

Based on the above extracts, it does appear that the involuntary withdrawal of the penis as a man attempts to penetrate significantly interrupts the sexual activity. Though the condition is not associated with any pain, such an experience is most likely to embarrass the man to an extent that future sexual activities may be avoided. One explanation given for this is that a woman will cause this to happen on her partner so as to prevent extra marital affairs.

d). Ejaculatory incompetence *(kutadza kutunda)*: According to some of the participants, an individual may have an erection followed by successful penetration, but may fail to ejaculate during sexual intercourse. It is believed that this problem might be initiated by a partner through some spiritual powers that will negatively affect the man's ejaculatory efforts. The experience is understood to be involuntary and disturbing to the individual. The following extracts illustrate this:

> *You will have an erection. But even after penetrating you will make movements (kuchokocha) with no ejaculation. The lady will even say to you, I am tired, and if you are failing to ejaculate just stop the sexual intercourse' (Participant 9).*
>
> *An individual may be affected using spiritual powers so that he or she may not have children even if they have sex. Clothing such as underwear or a simple thread is taken to the traditional healer who will mix it with some medicine. The name of the person to be affected is recited in the process for it to be effective (Participant 5).*

What the above quotations suggest is that some people have the spiritual powers that can remotely impair a man's sexual performance, resulting in failure to ejaculate. The condition is described by the participants as not harmful in that it might not to lead to pain or death for the man. However, it can be argued that the embarrassment that might result from the failure to ejaculate is most likely going to cause considerable psychological distress to the affected individual. This problem is believed to be caused by the actions of an aggrieved former girlfriend whose intentions might be to punish the man so that he will not have children. Some traditional healers are believed to have the ability to manipulate some forces using concoctions that can be given to the aggrieved girlfriend who will cause this sexual dysfunction to happen to the victim.

e). Infertility *(kupindura nyoka yemudumbu)*: Some participants are of the view that infertility in women can be caused by jealousy or the evil intentions of others. It is understood by the participants that an individual may use spiritual powers to affect the ovary from sending the ovum to the funnel of the oviduct. This is done by causing the funnel of oviduct to turn in the opposite direction. The quotation below illustrates this:

> *Some people have the power to turn a women's oviduct funnel (nyoka yemukadzi yemudumbu). There is one that releases ova and one that receives. The funnel is turned so that it will be unable to receive ovum (Participant 2).*

Like in the other sexual dysfunctions that were described above, it appears that infertility is attributed to the actions of others who are motivated by jealousy or evil intentions. By manipulating some spiritual forces, these individuals with evil intentions are believed to have the powers to remotely influence the reproductive abilities of others resulting in infertility. As with the other sexual dysfunctions above, infertility is believed to cause no physical pain even though there is a strong likelihood of psychological distress as a result of failure to conceive.

Subtheme 2: Other forms of sexual dysfunction (*kuuraya nhengo*)

According to the participants, some members of the community may be motivated by a strong desire to become rich or successful to the extent that they may consult a traditional healer to be assisted to diminish or stop their libido. This is understood as a voluntary action by the person who has the desire to be rich or successful. The extracts below illustrates this:

> *This person will consult a traditional healer to use his reproductive parts to help him/her become rich. In this case, a millipede is killed, crushed and mixed with some medicines and smeared on the private parts of the affected person. After two days of sexual abstinence, the person will lose their sexual feelings. The sexual organ will be there but will not be functional. Now such a person will be unable to engage sexually until he/she has visited a traditional*

healer to reverse the condition. The problem is that once the condition is reversed, the person's desire to get rich may be negatively affected (Participant 3).

What is suggested above is that the desire to be rich or to succeed can be so strong that it may motivate some individuals to voluntarily cause on themselves what appears to be a temporary sexual dysfunction. Some traditional healers are believed to have the ability to mix some concoctions that can be applied on the private parts thus resulting in the temporary sexual dysfunction. What is interesting about this self-induced sexual dysfunction is that it can be lifted when the affected individual feels like doing so.

Subtheme 3: Causes of sexual dysfunctions

a). Locking (*kusungwa*) and related conditions: It does appear from the findings of this study that some community members may have some evil intentions to the extent that they may want to make others suffer. This appears to be done through the manipulation and mobilisation of some spiritual forces that will remotely affect the person who is the target of these actions. The act of locking appears to be understood as the most common cause of the sexual dysfunctions.

Example 1: Tortoise (kamba): The excerpts from the participant' narratives suggest that some individuals may use preparations derived from the remains of a tortoise concocted with some medicines and semen/sperms or traces thereof in a condom to cause penis withdrawal in the targeted individual during coitus. The quotations below illustrate this:

The other type of concoction is to make the penis withdraw inside like a tortoise. You can travel with it from here to Bulawayo. This is the medication which is made (Participant 2).

Usually young boys have a sexual encounter and run away. However if the young lady is in possession of the used common with semen or sperms, the young man will be in trouble. The ladies know how to use the semen in the condoms and they will act fast to preserve the used condom and its contents. These secretions may later be taken to a traditional healer who may work on them to lock the young man (Participant 10).

As can be seen from the above extracts, the participants believe that some members of the community are driven by revenge to the extent that they can manipulate some spiritual force to make targeted person suffer. As can be seen from one of the extracts above, commercial sex workers, married and divorced women are believed to be engaging in this act.

Example 2: Ruware (Impenetrable vagina): According to some participants, a jealous community member may manipulate items such as stone and oil and the targeted person's underwear items to prevent a female from experiencing sexual penetration. The following verbatim expressions illustrates this:

In the case of females, a small stone is smeared with medication (mushonga/muti) and then rubbed on a woman's underwear. Alternatively, small stone may be smeared with oil and rubbed on and a female's underwear and left for 2 days. During sexual intercourse, the affected woman may be aroused and ready to engage in sexual intercourse but the vagina will not be open for penetration (Participant 1).

You take a lady's underwear and dip it in water from the hollow of a tree (mhango). Then as you dip the pant in that water call the name of the person and say that she must not experience a sexual penetration with a man, the man should not find where the vagina is. A man will not find any space to penetrate and may spend the whole night looking for it and will never find it (Participant 5).

What is suggested above is that jealousy may fuel others to act in such a way that they may result in associated illness affecting those that they envy. It does appear that jealous relatives or partners are the ones that are more likely to act in this ways.

Example 3: Item and medicine (hembe kana chipenga nemushonga): The participants indicated that an individual could experience illness associated with mental illness because the partner has taken a thread or piece of underwear from them. This is mixed with medication causing the penis to fail to experience an erection. The following verbatim expressions illustrate this:

> *The women are now much clever these days and they will cause erection failure. So in marriage the wife will take thread from the husband's underwear and keep it. Then when they divorced she will bring them to the traditional healer who will conduct his procedures which could result in inability for the ex-husband to experience an erection. You will struggle especially if you are young and you will waste a lot of money to restore the erection (Participant 9).*

From the above extracts, it can be suggested that the participants believe that women who have been hurt through divorce do this to get back at their ex-husbands. They do this to get their revenge by making the man suffer as he is locked.

b). Treatment of associated illnesses: Since associated illnesses are believed to be caused by spiritual forces, there is a strong view that external factors should also play a major role in their treatment. The examples below highlight the kinds of explanations that the traditional healers give in respect of the treatment of associated illness:

Example 1: Unlocking (kusunungura): According to participants, an individual can be treated from associated illnesses by rubbing medicine on his penis. The veins which were blocked during locking will be unblocked and erection will be restored. The following verbatim expression illustrates this:

> *When your sexual system has been locked, you cannot be assisted at the hospital. You would need assistance from a person who knows what was used in the first place. You will just rub the medicine on the penis and follow a few procedures then your erection will be restored. The veins in your penis would have been blocked so in the unlocking process they will be re-opened. Even the Apostolic sect will not be able to resolve this, however they might be able to resolve other issues (Participant 7).*

What is suggested above is that erectile dysfunction is caused by spiritual forces and can be resolved only through traditional treatment. Divination helps to give a narrative of how someone was locked, which allows it to be resolved.

Example 2: Treatment of infertility (kusimikira): It does appear from the findings of this study that there is a pant that is used to treat infertility. The medicine is prepared carefully and taken orally by the affected female. The quotations below illustrate this:

> *There is also medication to boost fertility in females (kusimikira). The medication is like runner grass and needs special care. It should not be loose but be tied together. The roots should be tied with the soft part of the bark of a musasa tree and kept in water. When taking this medication no matter the problem the person will definitely conceive. If one drinks the water she will conceive (Participant 3).*

As can be seen from the above extracts, the participants are of the view that a plant can be used to reverse infertility.

Example 3: Use of elephant dung (ndove yenzou): In some cases, animal excrement (such as elephant's dung) is used to ease the delivery of babies. People are usually locked to prevent smooth birth, in order to result in fatal problems. The elephant's dung is used symbolical to its destruction of barriers. The quotation below do reflect this belief by some of the participants:

> *Pregnant women use elephant's dung to help smoothen the delivery of the baby. It can also be used when the days are past 09 months. This treatment resolves a problem when someone has been trapped (kuteya) in pregnancy (Participant 5).*

What the above extracts suggest is that some people have the powers to manipulate living and non-living forces in the universe to make women suffer. It is believed that through such actions, this problem can be resolved through the use of the elephant's dung to ease complicated birth.

PART B: PSYCHOLOGICAL DESCRIPTION AND INTERPRETATION

5.4 Conceptualisation of mental illnesses

The present study suggests that the participants have their way of determining mental illness. The themes that emerged from the findings seem to suggest that psychotic and some anxiety symptoms are what is seen as the clinical features of mental illness. There are some commonalities and differences between these features and those identified in the case of some psychotic and anxiety disorders as outlined in the Diagnostic and Statistical Manual 5 (DSM 5). The participants also identified and described other clinical conditions which they associated with mental illness. These included epilepsy and sexual dysfunctions. Whilst the sexual disorders are classified in the DSM 5 under mental disorder (APA, 2013), epilepsy is categorised as a nervous system condition (Schachter, 2014). In the case of Shona traditional healers, the two clinical conditions (that is, sexual dysfunctions and epilepsy) are perceived to be associated with but not regarded as mental.

5.4.1 Psychotic features

5.4.1.1 Difficulties with self-care: A number of difficulties with self-care were reported by participants as characteristics of mental illness. People who become mentally ill are not concerned about good hygienic habits. They tend to scavenge for food from bins, refuse to bath or wash their clothes and have bad eating habits. They lose the ability to restrain their habits within the normal range and are seem to have created a reality which is skewed. In their frame of reference, they seem to be convinced that they function normally because their mental abilities are no longer functioning well. Difficulties in self-care tend to affect how they take care of their children. Social and occupational function is also affected probably resulting in loss of relationships and employment depending on severity. The sense of responsibility which an individual used to have is no longer evident.

5.4.1.2 Disorganised behaviour: Participants identified a number of actions which represent disorganised behaviour as characteristics of mental illness. Typical disorganised behaviour patterns include the following: inappropriate laughing (*kuseka zvakapfuura mwero*), talking to self (*kutaura wega*), illogical thoughts (*kurotomoka*), derailment (*kurasika pakutaura*), failure to recognise familiar people (*kukanganwa hama dzepedyo*) and wandering about (*kusagara pasi*). Mentally ill people turn to behave differently from those without mental illness. They may laugh when there is nothing funny, and may also engage in unintelligent speech. These kinds of behaviour are often believed to be associated with the presence of one or more spirits communicating. It is the traditional healer who is believed to have the powers and capacity to access the spiritual world and to assess, diagnose and treat these kinds of problems.

5.4.1.3 Perceptual disturbances: Mentally ill people are understood to be experiencing sensations which other people do not experience. Participants identified that if an anti-hill and termites have been used to cause mental illness, the victim will feel termites moving up and down as if they are on the skin. A spiritual force is said to be causing this. These mentally ill people may even be seeing people

who died a long time ago and talking to them. What is suggested here is that it must be stressful for the mentally ill person to be having these experiences that other people do not have. In other words, their sense of reality becomes different from that of other people.

5.4.2 Anxiety symptoms

5.4.2.1 Physical complains: A headache was identified as one of the common physical symptoms associated with mental illness. The participants perceived this symptom to be severe, thus suggesting poor prognosis if not attended to quickly. Some spiritual forces are understood to be the cause of these headaches, with the results that spiritual intervention is often indicated.

5.4.2.2 Heart palpitations: Participants reported that the mentally ill may experience a racing heart without anything frightening. This is better accounted for by a spiritual cause because it cannot be seen by those around the person. An individual with mental illness may have a heart beat that resembles that of a person doing an exercise while it is not the case. This must be stressful and confusing to the participant who is sure that they have not been exercising.

5.4.2.3 Feeling dizzy: Participants indicated that the mentally ill may have feelings of dizziness. These feelings are believed to be caused by some spiritual forces that may be sent through witchcraft to cause mental disturbance. The affected individual finds it difficult to understand what is happening and why. The interventions of a traditional healer through divination is what is believed to resolve the problem.

5.5 Causes of mental illness

Mental illness is understood to be caused by both internal and external factors. This study revealed a strong view that the external factors, predominantly, some spiritual forces) play a bigger role. Internal forces seem to share an understanding with the biological factors. Surprising, it is evident in a number of cases that accidents are at times attributable to some spiritual forces that could be at play. When considering all situations accidents will fall in both biological and spiritual factors.

5.5.1 Internal factors: Heredity and head trauma were the two common internal factors that were perceived by the participants to be the causes of mental illness.

a). Heredity: Some of the participants did indicate that heredity is one of the causal factors of mental illness, with some mental illnesses being believed to run in families. If a parent has mental illness, the children and other off-springs are more likely to have mental illness. The implication here is that the participants perceive mental illness to be a family disease. This conceptualisation of mental illness does seem to be similar to the view held in the biomedical system which has found that there is some association between heredity and mental illness.

b). Head trauma: Head injuries were reported by some participants to be the cause of mental illness. The participants were of the view that these head injuries are a result of some spiritual forces as accidents do not just happen without a reason. The occurrence of accidents result in the mixing of blood and the brain and this is believed to result in mental illness.

5.5.2 Cultural factors (External factors): Various spiritual forces were perceived by the participants to be causes of mental illness. These spiritual forces include witchcraft, avenging spirits and the spirits which follow an ancestral spirit. Witchcraft has been reported to be stemming from jealousy, envy and the dislike of the life or achievements of others which motivates someone to cause harm on another. The findings revealed that individuals engaging in witchcraft are motivated by the evil

intentions of causing harm on others. In this regard, it is understood that animal like creatures such as birds or cats may be sent to cause harm. In some cases, spirits of dead people and non-living entities like an anthill can be manipulated by persons with evil intentions to cause mental illness on others. Some evil people are also believed to manipulate the spirits of the living people in order to get rich. The person whose spirit is manipulated will become mentally ill.

The findings also indicated that there are various types of avenging spirits which result in mental illness. The belief here is that someone who is wronged while alive and does not receive restitution, may after death cause the offending person to become mentally ill. For example, a mother who is wronged by her own child or children, or a wife wronged by her husband might after her death cause the offending person to become mentally ill. At times, failing to do what the ancestors want (*kusaitira mudzimu zvaunoda*), could result in the offending person not receiving protection from the ancestral spirits and subsequently becoming mentally ill.

In the case of someone stealing from others, there is a possibility that such a person can be afflicted with some form of illness, including mental illness. In this regard, it is believed that the wronged person may take an item (like the offending person's piece of clothing or footprints) from the scene where the crime was committed and concoct this with some herbs to cause mental illness to the offending individual.

Whilst there are good spirits that promote good health and protect the living, it is also believed that that there are some bad spirits which will always be there to counter the effectiveness of these good spirits. For example, an evil spirit may follow a spirit medium (*mweya yakaipa inotevera mudzimu*) before initiation which may result in the potential traditional healer becoming mentally ill. There is therefore a need for traditional healers to always do an assessment to ensure that the initiation of a budding traditional healer is not sabotaged by the evil spirits, thus resulting in mental illness. Another example of a bad spirit is that of a love portion (*mupfuhwira*) that may negatively affect a marriage (and lead to mental illness) if the evil spirit is manipulated to counter the good spirit.

5.6 Diagnosis and treatment of mental illness

The findings of the present study suggest that there are various diagnostic and treatment methods that traditional healers use to deal with mental illness. Among others, the diagnostic and treatment methods include *kushopera* (divination), *girazi* (looking glass), *kurotswa* (using dreams) and the use of *mushona* (medicines). In other words, it does appear that there are well defined diagnostic and treatment methods that traditional healers use.

5.6.1 *Kushopera* (Divination): Through divination (*kushopera*) the traditional healer is able to determine and explain mental illness and its causes. It is believed that such ability is bestowed to the traditional healer by the ancestral spirits. This suggests that that traditional healing is not guess work, but a systematic activity that is facilitated by ancestral spirits.

5.6.2 *Girazi* (Looking glass)*:*** *Girazi* (looking glass) could be interpreted as some form of a projective assessment method that traditional healers use to examine a patient without touching them. This seems to differ from the Western medical procedures that require constant physical touching by a medical practitioner.

5.6.3 *Kurotswa* (Use of dreams)*:*** Through the use of dreams that are believed to be moderated by the ancestral spirits, the traditional healer is believed to be able to determine a patient's problem and the appropriate treatment that should be prescribed. The dreams are also believed to guide the traditional healer in preparing and administering the medicine. In other words, the ancestral spirits do have some role in regulating the type and content of medical preparations that are administered on the patients. Unlike what happens in Western medicine, it does appear that in African traditional healing there are no written guidelines on the dosage amounts of medicines. Instead, the dosage amounts appear to be dependent on spiritual guidance and the experience of the traditional healer.

5.6.4 *Mushonga* (Medicine): The results of the study suggest that proper diagnosis is followed by treatment which resolves the problem. A number of treatment procedures involving animal and plant extracts are used. These include various *mushonga* (medicines) which are concocted with items such as animal and plant extracts and administered to the mentally ill person. In administering these medicines, the traditional healer is believed to be constantly guided by ancestral spirits, helping him/her to make the right choices of medicines that will cure specific problems.

There are different methods of administering medicine to patients. In some cases, the patients will be expected to engage in some recitals which are aimed at "chasing" the evil spirit from them whilst the medicines are being administered. The medicine that is taken orally (such as *njuzu yemukosvi)*, is ground into some powder and then mixed with water. This is then added to foods such as soft porridge for easy intake. Some of the medicine can be taken through bathing and lacerations (*kutemera nyora*).

Traditional healers are expected to test the medicine they administer to the patient by first consuming a small amount before the medical preparation is administered to the patient. This is believed to demonstrate to the patient that the medicine will be safe and effective.

5.6.5 Treating evil spirits: The study found that traditional healers use a number of procedures that they believe can remove evil spirits from their patients. For example, a domesticated animal may be used to *kusudurudza mhepo* (push away the bad spirit) from the affected person. In this instance, the mental illness is symbolically transferred onto the domestic animal which will carry away the illness into the woods. In so doing the animal will move away with the evil spirit thereby resolving the mental illness which was in a person.

In other instances, an evil spirit can also be redirected from a patient to afflict a wrongdoer (*kutaurira mweya wakaipa*) when trying to resolve mental illness. In this case, it is believed that a traditional healer has the capacity to redirect an evil spirit to the individual who has caused the mental illness to affect the innocent patient. This kind of action reverses the mental illness and redirects it to the offending individual.

In other words, mental illness is understood to be transferable depending on the spiritual powers that are bestowed on the traditional healer.

Evil spirits can be induced to talk (*kudhonza mhepo*). In this instance, a traditional healer will prepare and administer some medicine to a client so as to provoke the evil spirit to reveal its intentions. The traditional healer will then engage the evil spirit because he/she is believed to have spiritual connections. Once the intentions of the evil spirits are communicated and addressed where possible, the good mental health of the patient may be restored.

The participants in the present study did point out that every wrong doing by a family member that is not corrected through compensation (*kuripa*) will lead to mental illness. Examples of wrongdoing include ill-treating ones' mother and killing someone. Once something wrong has been done and the spirit of the aggrieved person avenges, it will result in the offender or family member having mental illness. In such situations the aggrieved spirit has to be engaged and compensated with whatever is demanded to restore good mental well-being to the affected person.

5.7 Challenges faced by traditional healers

Every profession has particular challenges that are faced by its members. Similarly, the present study found that traditional healers have a number of challenges as well. These include treatment failure, a traditional healer's emotional states such as anger, and jealousy.

5.7.1 *Kutadza kushanda kwemushonga* (Treatment failure): The participants pointed out that despite correct diagnosis, treatment is not always effective. Some treatment that may have worked for one patient may not work for the other one. Traditional healers believe that for medicine to work effectively, it should have entered the blood stream to cause changes. Some participants attributed treatment failure to incompatibility between the patient's blood and the medicine that is administered. In some cases, the incompatibility may be between the patient and the traditional healer. In this case, a good traditional healer will be expected to refer the patient to a colleague who may be better placed to help the patient better. This

suggests that there is provision in traditional healing for a patient to seek and receive a second opinion.

5.7.2 *Kutsamwa* (Anger): Emotions such as anger (*kutsamwa*) has been found to negatively affect the effectiveness of the interventions of a traditional healer. In other words, traditional healing requires constant emotional stability as negative emotions hinder positive treatment outcomes. Similarly, a traditional healer is expected to have a good attitude when dealing with patients. Poor attitude is believed to negatively affect treatment outcomes. Other emotions that are also believed to lead to negative treatment outcomes are anger and jealousy.

5.7.3 *Kuba* (theft of ideas and intellectual property rights): Traditional healers are concerned with theft of their ideas and intellectual property rights (*kuba*). The participants in the present study pointed out that they feel betrayed by other professionals who steal their ideas. They reported that they are prepared to share their ideas with other professional provided there is fairness. It does appear that the current power dynamics in the health care system makes traditional healers vulnerable and could thus benefit from legislation that could be intended to protect their indigenous knowledge.

5.7.4 *Rusarura* (discrimination): Discrimination (*rusarura*) is another threatening challenge to traditional healers within the health sector. Traditional healers who participated in the present study felt that the health authorities and churches treat them unfairly. Despite feeling discriminated against, the participants felt that it is important for them to recognise the usefulness of churches and western trained health practitioners.

5.8 Facilitating factors in the work of traditional healers

The participants identified some factors that they perceived to facilitate their work. These include honesty, flexible payment arrangements and continuous professional development.

5.8.1 *Kuvimbika* (Honesty): The participants pointed out that they receive remuneration only for the work done. They do provide refunds to their clients in situations where treatment was offered but not completed. Clients are provided with information on the treatment process and the cost involved, thus allowing the patients to make an informed decisions before they can receive the treatment. This suggests that there is an element of honesty as the clients are not trapped in a treatment process that might not favour them. Traditional healers encourage second opinion and refer their clients to other practitioners when they do not have the competence to deal with that particular client.

5.8.2 *Kubhadhara kwakareruka* (Flexible payment arrangements): The participants pointed out that they are concerned with the affordability of their services (*kubhadhara kusingaremere vanhu*). In this regard, they try to make their services accessible by negotiating the terms of service delivery with their patients. For example, a traditional may agree to keep a patient's valuable item (such as a microwave or DVD player) in lieu of payment until the patient has accumulated enough money to pay for the services.

5.8.3 *Kudzidzisana* (Continuous professional development): The participants indicated that the nature of their work required them to keep on learning from each other in order to grow their levels of competence. They are usually prepared and willing to learn from those with knowledge and experience while they are willing to teach others what they know better. This openness to learn and teach means that traditional healers acknowledge the limitations of their abilities. Based on this observation, it can be suggested that traditional healers have developed their own continuous professional development arrangements that are based on the principles of sharing, trust and peer education.

5.9 Conceptualisation and treatment of associated illnesses

Associated illness are conditions that do not qualify to be referred to as mental illness but are considered to be closely associated with mental illness. People suffering from these associated conditions will show some significant psychological distress but will not receive the diagnosis of mental illness. The three associated conditions that were identified by the participants are *pfari* (epilepsy), *kusungwa* (locking) and *kuuraya nhengo kana chinhu* (sexual dysfunctions).

5.9.1 *Pfari* (epilepsy)*:*** People with what is known as *pfari* suddenly experience the following symptoms: a). temporary confusion and formed visual hallucinations (for example, visions of animal-like creatures); b). seizures resulting in non-purposeful movements; and, c). drooling. This condition appears to have similar clinical features with what is known as epilepsy in Western medicine.

5.9.2 *Kusungwa* (sexual dysfunctions): Traditional healers believe that some patients experience sexual difficulties (*kusungwa*) at some point in their sexual lives. Such difficulties may result on the affected individual not experiencing any of the following: physical pleasure, sexual desire, arousal or orgasm. *Kusungwa* includes the following *kufuratidzwa moyo* (losing sexual interest), *kutadza kumira kwenhengo yemurume* (erectile dysfunction), *kudzokera mukati kwenhengo yemurume* (involuntary penis withdrawal), *kutadza kutunda* (ejaculatory incompetence), other forms of sexual dysfunction (*kuuraya chinhu*) and *kupindura nyoka yemudumbu* (infertility).

a). *Kuratidzwa moyo* (loss of sexual interest): Traditional healers believe that an individual may lose sexual interest (*kuratidzwa moyo*) as evidenced by sudden loss of interest in sexual activities with a partner. When severe, the person may not want to see a person of the opposite sex. The participants were of the view that this kind of condition can be viewed positively if it could help married couples to avoid extra-marital affairs which may in turn reduce sexually transmitted diseases (such as HIV/AIDS).

b). *Kutadza kumira kwenhengo yemurume* (erectile dysfunction): In this case, a man fails to experience or maintain an erection though there is no physical pain experienced. At times a man may experience what is considered selective erections. For example, he may only experience and maintain an erection with his wife, but fail to do so when attempting to engage in a sexual act with another woman. This kind of sexual dysfunction is believed to be engineered by a spouse who may have the spiritual powers to cause such a temporary dysfunction. In other words, a woman may have the ability to stop a spouse from having an extra marital relationship by resorting to causing the husband to have this condition. The condition may also be brought about by an ex-partner following a bitter separation or divorce. In some cases, it is believed that some women may have spiritual powers to "lock" their husbands' sexual organs to an extent that the affected individual will fail to have or maintain an erection when they are trying to engage in sexual intercourse with another woman.

c). *Kudzokera mukati kwenhengo yemurume* (involuntary penis withdrawal): A man can also experience involuntary penis withdrawal when he tries to penetrate a woman. However, erection maybe restored as soon as the penis is ejected. This involuntary ejection significantly interrupts the sexual activity and is most likely to embarrass the man to an extent that future sexual activities may be avoided. It is interesting to note that this condition is not associated with any pain. Traditional healers believe that a woman will cause this to happen on her partner so as to prevent extra marital affairs.

d). *Kutadza kutunda* (ejaculatory incompetence): A man may have an erection followed by successful penetration, but may fail to ejaculate (*kutadza kutunda*) during sexual intercourse. Just like penis withdrawal, this condition is not associated with any pain. This condition might be initiated by a partner through some spiritual powers that will negatively affect the man's ejaculatory efforts. The failure to ejaculate will most likely cause considerable psychological distress to the affected individual. This problem is believed to be caused by the actions of an aggrieved former girlfriend whose intentions might be to punish the man so that he will not have children.

e). Kuuraya nhengo (Other forms of sexual dysfunction): Other forms of sexual dysfunction is when one is motivated by strong desire to become rich or successful to the extent that they may consult a traditional healer to be assisted to diminish or stop their libido. It is believed that their failure to engage sexually might create a lot of wealth for them. However, as opposed to other sexual dysfunctions, this particular type is self-afflicted voluntarily by a person who has the desire to be rich or successful. Specific medicine and animal parts are used in the process of making the sexual organ inactive. This condition is believed to be temporary and can be reversed by a traditional healer.

f). *Kupindura nyoka yemudumbu* (infertility): A woman may become infertile (*kupindura nyoka yemudumbu*) as evidenced by inability to fall pregnant and have children. It is believed that some spiritual powers can be manipulated to bring about this condition. It appears that infertility can be attributed to the actions of others who are motivated by jealousy or evil intentions. Infertility is believed to cause no physical pain even though there is a strong likelihood of psychological distress as a result of failure to conceive.

5.10 Causes of associated illnesses

5.10.1 Causes of *pfari* (epilepsy)

Two causal factors for *pfari* have been identified by the participants. These include: *huroyi* (witchcraft) and *chirwere chemumhuri* (heredity).

5.10.1.1 Huroyi (witchcraft)*:* The participants were of the view that *huroyi* (witchcraft) can cause associated illnesses like *pfari* (epilepsy). These actions are motivated by envy and jealousy which pushes some individuals to harm others. In the case of *pfari, zvikwambo/zvishiri* (goblins) which are animal-like creatures, are believed to be sent by the person with evil intentions to attack the targeted person.

5.10.1.2 *Chirwere chemumhuri* (heredity): Heredity is also considered to be a causal factor in the associated illnesses like *pfari*. It is seen when blood relatives from different generations present with *pfari*.

5.10.2 Causes of sexual dysfunction

A number of causal factors for sexual dysfunctions have been identified by the participants. These include: the use of *kamba* and *chipfeko chepasi nematombo kana mvura* (item and underwear).

5.10.2.1 The use of kamba (tortoise remains): It is believed by the participants in the present study that different animal and animal parts can be used in making concoctions that can result in some sexual dysfunctions (*kusungwa*). For example, *kamba's* (tortoise) remains may be concocted with some medicine and semen/sperms or traces thereof in a condom to cause a man's penis to withdraw during sexual intercourse. These sexual fluids so collected may be to "lock" a man's sexual organs and thus preventing him from having any pleasurable sexual intercourse. It is believed that those who are driven by revenge may engage in this action to get back to a lost lover.

5.10.2.2 Chipfeko chepasi nematombo kana mvura (Some items and a woman's underwear): Women can experience sexual dysfunction called *ruware* (impenetrable vagina) when a jealous lover or relative manipulates items such as stone, oil and underwear of the targeted female, with the help of a traditional healer. The stone is dipped into oil or water from the hollow of a tree (*mhango*) and rubbed on the underwear while instructing that the intended individual should never experience sexual penetration. The individual so afflicted may experience some sexual arousal, but will have difficulty as a man tries to penetrate her during sexual intercourse without success.

5.11 Treatment of associated illnesses

5.11.1 Treatment of pfari (Epilepsy)

Generally divination is used to establish what might have caused a problem and how it can be treated. If an illness is understood to have been caused by mistakes committed by an individual, the illness can be transferred to a domestic animal. For example, in the case of *pfari,* it is understood that the condition will have been symbolically transferred onto the domestic animal which will carry away the illness into the woods.

5.11.2 Treatment of *kusungwa* (Sexual dysfunctions)

The participants pointed out that different animal and plant material is used to treat *kusungwa* (sexual dysfunctions).

5.11.2.1 *Kusimikira* (Fertility boost): Women who are struggling with infertility can be assisted by a traditional healer to resolve their problem by using *kusimikira* (fertility boost). The traditional healer will carefully prepare a plant which is like runner grass by tying it with the soft part of the back of a *musasa* tree and keep it in water. The affected person will drink the water which will then resolve the fertility problem.

5.11.2.2 *Kusunungura* (Unlocking): Different types of sexual dysfunctions can be resolved by "unlocking" (*kusunungura)* the affected sexual system. Medicine which was prepared by the traditional healer will be rubbed on the tip of the sexual organ in order to resolve the dysfunction, which is believed to be the result of blocked veins.

5.11.2.3 *Ndove yenzou* (Elephant's dung): Animal excrements such as elephant's dung are believed to ease the delivery of babies. Usually some people are influenced by jealous to lock a female to prevent smooth birth process. Traditional healers will make a pregnant woman to drink water that has been laced with elephant's dung. Symbolically, it can also be argued that the elephant's dung represent the strength of an elephant which can remove barriers. This suggests that traditional treatment can be used to reduce infant mortality.

5.12 Concluding remarks

In this chapter, the findings of the study were presented. Five themes linked to mental illness and three themes of associated illnesses were identified and described. The five themes linked to mental illness were the following: a) types/characteristics of mental illness, b) causes of mental illness, c) diagnosis and treatment of mental illness, d) challenges faced by traditional healers, and e) facilitating factors in the work of traditional healers were presented and highlighted. The two themes linked to the associated illnesses are the following: a) epilepsy (p*fari*), and b) sexual dysfunctions (*kusungwa*) focusing on their types/characteristics, causes, and treatment. The psychological description and interpretation on conceptualisation of mental illness and associated illnesses by Shona speaking traditional healers were presented. In the next chapter, the results of the study are discussed in the context of existing literature on the subject.

CHAPTER 6

DISCUSSION OF THE FINDINGS

6.1 Introduction

The aim of this chapter is to discuss the results of the present study in the context of the existing body of knowledge on the subject of the role of traditional healers in the treatment of mental illness. The first section of the discussion will focus on conceptualisation of mental illness by traditional healers. In this regard, the section covers issues pertaining to the characteristics, causes and treatment of mental illness as understood and described by traditional healers. The second section covers the facilitating factors and challenges in the work of traditional healers. The third section covers the conceptualisation of associated illnesses, and address issues like the characteristics, causes and treatment of associated illnesses.

6.2 Conceptualisation of mental illness by Shona traditional healers

6.2.1 Characteristics of mental illness

This study identified culturally explained characteristics of mental illness that, in Western medicine and psychology are referred to as symptoms of mental illness. Based on the shared views of the participants in the study, this study identified the following ten characteristics of mental illness: a) disorganised behaviour and related features; b) failure to recognise familiar people (*kukanganwa hama dzepedyo*); c) derailment (*kurasika pakutaura*); d) occupational impairment (*kutadza kushanda*); e) falling (*kupunzika*); f) mutism (*kunyararisa*); g) increased or irregular heartbeat (*kurohwa nehana*); h) headache (*kutemwa nemusoro*); i) dizziness (*dzungu*); and j) perceptual disturbances. These characteristics indicate that Shona Zezuru traditional healers perceive mental illness to be characterised mainly by what Western medicine and psychology regard to as psychotic and anxiety symptoms. The above ten characteristics can be further grouped into behavioural and physiological characteristics. The behavioural characteristics are the following: disorganised behaviour and related features, failure to recognise familiar people (*kukanganwa hama dzepedyo*), derailment (*kurasika pakutaura*), occupational impairment (*kutadza*

kushanda), falling (*kupunzika*), and tactile sensation (*kufambwa fambwa*). The physiological characteristics are as follows: increased or irregular heartbeat (*kurohwa nehana*), headache (*kutemwa nemusoro*), and dizziness (*dzungu*). The above descriptions about the characteristics of mental illness suggest that traditional healers do not have an elaborate nosological system that recognises a variety of mental illnesses. Instead, they tend to focus more on the description of what could be considered the symptoms instead of giving nosological labels to the conditions. The findings of the present study lent support to a previous study by Ngobe (2015) who also found that Swati traditional healers tended to understand mental illness mainly on the basis of the characteristics of the condition instead of the diagnostic labels.

The results of the present study are consistent with the results of earlier studies by Mufamadi and Sodi (2010) and Sorsdahl, et al. (2010) which found that traditional healers tended to regard patients experiencing psychotic symptoms as mentally ill. However, the present study identified the following characteristics of mental illness that were not indicated in previous studies: a) failure to recognise familiar people (*kukanganwa hama dzepedyo*); b) derailment (*kurasika pakutaura*); c) occupational impairment (*kutadza kushanda*); d) falling (*kupunzika*); and e) tactile sensation (*kufambwa fambwa*). The current findings also support the findings of other studies that have identified severe psychotic disturbances as indicators of mental illness in many African communities **(**Mufamadi, 2001; Mzimkulu & Simbayi, 2006; Patel, 2001; Patel, Simunya & Gwanzura, 1997). A previous study by Sorsdahl, et al. (2010) found that traditional healers associate mental illness with extreme behaviours that include picking up garbage, talking randomly, and walking for long periods of time. Unlike in the case of the present study, Sorsdahl, et al. (2010) also found that those who are considered to be mentally ill tend to undress in public as part of extreme behaviours.

What the above findings suggest is that there seems to be some convergence between Western notions of psychotic behaviour and the traditional healers' notions of mental illness. In other words, it does appear that traditional healers tend to consider only psychotic features as the threshold for what could be considered mental illness. In this sense, this seems to contrast the Western notions of mental illness that include both indications of psychotic and non-psychotic behaviour. For

example, the Diagnostic and Statistical Manual 5 (DSM 5) considers mental illness to be characterized by cognitive and emotional disturbances, abnormal behaviours, impaired functioning, or any combination of these (APA, 2013, 2015).

6.2.2 Causes of mental illness

The study revealed that mental illness is understood to be caused mainly by spiritual and biological factors. The spiritual factors include the following: a) witchcraft (*huroyi*); b) avenging spirits (*ngozi*); c) theft (*kuba*); d) bad spirits which follow spirit medium (*mweya Yakaipa inotevera mudzimu*); and e) love portion (*mupfuhwira*). The biological factors include head trauma (*kusangana kweropa nehuropi*) and heredity (*chirwere chemhuri*). Some previous studies have also found that mental illness in some African communities is attributed to spiritual and biological factors (Ngobe, 2015; Muchinako, et al., 2013; Sorsdahl, et al., 2010; Maiello, 2008). For example, studies by Crawfod and Lipsedge (2004), and Muchinako, et al. (2013) have suggested that sorcery is a common cause of mental illness in Zulu (South Africa) and Shona (Zimbabwe) societies respectively. In an earlier study, Campbell-Hall, Petersen, Bhana, Mjadu, Hosegood, Flisher, & MHaPP (2010) found that mental illness can be attributed to spiritual factors in cases where the living neglect their ancestors. Cases of ancestral neglect include: a) the living refusing to carry out the orders of ancestors, and b) failing to conduct the required cultural rituals and ceremonies. In such instances, it is believed that ancestors have the powers to cause discomfort (including mental illness) in the living.

The results of the present study are consistent with the results of an earlier study by Muchinako, et al. (2013) which found that mental illness is caused by avenging spirits, love portion, and magic charm. These causal explanations by traditional healers suggest that spiritual forces are seen to have the capacity to cause mental illness. Whilst there were some similar causes of mental illness identified by the previous and the current study, there were also some points of divergence. For example, an earlier study by Muchinako, et al. (2013) found that Shona community members in Zimbabwe attribute mental illness to a range of factors that include aging, alcohol and drugs, diseases, employment problems, and political influence. The study by Muchiako et al. does seem to suggest that the causal explanation for

mental illness in Zimbabwe should be broadened to include sociocultural factors. By acknowledging the sociocultural causal factors, it could therefore be argued that communities in this cultural environment are beginning to accommodate the Western causal explanations of mental illness.

Like in the previous studies by Ngobe (2015), and Mbwayo, Ndetei, Mutiso and Khasakhala (2013), the current study found that traditional healers believe that mental illness can be inherited or may result from an accident. A study by Mbwayo, et al. (2013) also made similar observations but went on to suggest that substance and alcohol abuse could also be causal factors in mental illness. What the present study and the study by Mbayo et al. seem to suggest is that there is some degree of convergence between traditional and Western healing systems when it comes to the biological causes of mental illness. Whilst the two systems do agree to some extent regarding the biological basis of mental illness, the practitioners in the two systems do not share the same level of understanding in terms of clinical detail. For example, Kolb and Wishaw (2009) point out that even though traditional healers and Western trained health practitioners might agree that head trauma causes mental illness, the understanding of the clinical detail in the two systems is not the same. In other words, whilst Western trained health practitioners might explain the mental illness in terms of actual damage to brain tissue and change in human behaviour, a traditional healer might suggest that the mental illness is the result of the blood mixing with the brain, thus resulting in dirt that needs to be cleaned from the brain**.**

6.2.3 Diagnosis and treatment of mental illness

6.2.3.1 Diagnosis of mental illness

Some of the participants suggested that ancestral spirits guide them in making the diagnoses of their patients' mental illness. In this regard, a number of diagnostic tools or procedures are used. These include: a) *kushopera* (divination); b) *girazi* (looking glass); and c) *kurotswa* (using dreams). The traditional healers indicated that they use these tools and procedures to determine what is troubling their patients. In a study that focused on the provision of mental health services in a cosmopolitan informal settlement in Kenya, Mbwayo, et al. (2013) also found that traditional healers make use of divination bones to diagnose and treat patients. Like

in the present study, the influence of ancestors was found to be paramount in these diagnostic activities. Whilst there are some variations in the types of tools that traditional healers use in making the diagnosis, it does appear that there are broad similarities in the diagnostic procedures followed by the traditional healers in Kenya and Zimbabwe. For example, the present study and the previous one by Mbwayo et al. suggest that traditional healers rely on ancestral guidance to diagnose mental illness in their patients. Similar findings have been reported in other studies that investigated the diagnosis and treatment of mental illness in other African countries. A study by Ngobe (2015) found that traditional healers use a holistic approach which neutralises sorcery or appease ancestors in order to create harmony. In South Africa a study by Starkowitz (2013) found that medicine alone does not address the spiritual aspects of illness such as depression and the intervention of a traditional healer explores the spiritual influence to see maybe how one has displeased ancestors. A study by Abbo (2010) in Uganda also found that the strong belief in supernatural factors causing mental illness will be resolved through divination which depends on the influence of ancestors.

Generally, what the above studies seem to suggest is that traditional healers need the constant guidance of the spiritual beings to diagnose and treat the conditions of their patients. What this means is that traditional healing is not guess work but a body of knowledge that is culturally meaningful and guided by spiritual forces.

6.2.3.2 Treatment of mental illness

Participants in the present study identified a number of interventions that are used in the management of patients with mental illness. These include the following: a) dealing with bad spirits (*kubvisa mweya yakaipa*); b) compensation (*kuripa*); and c) the use of medicine (*mushonga*). Traditional healers indicated that mental illness is treated by achieving balance using ways of dealing with bad spirits (*kubvisa mweya yakaipa*) which included negotiating with spirit (*kutaurirana*), and pulling the spirit to talk (*kudhonza mhepo*). The above descriptions about the ways of treating mental illness suggest that traditional healers look beyond the physical treatment of the illness by focusing on the spiritual issues as well. Engaging the evil spirit results in discovering how to bring harmony between the living and ancestors. Like in the

previous study by Mbwayo, et al. (2013), the present study found that a spiritual approach to treatment of mental illness restores peace and harmony between the ancestors and the living.

The results of the present study are consistent with the results of earlier studies by WHO (2006) and Komla (1997), which found that traditional healers tended to seek to restore harmony, balance and equilibrium, not only by alleviating physical symptoms, but also by adequately dealing with the spiritual factors that ultimately account for misfortunes. A previous study by Mzimkulu and Simbayi (2006) found that Xhosa-speaking African traditional healers treated psychosis by cleansing patients and their families of evil spirits through various rituals. Unlike in the case of the current study, Western approaches on mental illness focus only on the physical and psychological aspects and not on the spiritual component. For example APA (2013) considers the neuropsychological factors to be treated by medication and the psychosocial stressors to be resolved through psychotherapy.

The current study revealed that any wrong which has been committed against anyone should be resolved to avoid any possibility of avenging spirits later coming to haunt the offending individual and his/her family. The findings of the present study lent support to a previous study by Muchinako, et al. (2013) who also found that Shona society in Zimbabwe tended to believe that mental illness caused by avenging spirits (*ngozi*) can only be treated through compensating the aggrieved (*mushonga wengozi kuiripa*).

The above findings suggest that the Western treatment for mental illness will not resolve mental illness caused by the avenging spirits. In other words traditional healers tend to consider compensation (*kuripa*) as the best way to resolve this kind of mental illness. Medication alone will not lead to treatment as the spiritual component would not have been resolved. This means there will be no harmony between the spirit of the aggrieved person and the living until the necessary compensation has been given.

The participants reported that medicine which includes plant and animal extracts is used in the treatment of mental illness. The plant extracts include the following: a) *njuzu yemukosvi*, and *mushonga wekuchaisa* (cultural laxative), while animal extracts are from an insect called *pfuta*. The above descriptions about medicine for treatment of mental illness suggest that traditional healers recognise that different types of materials which have medicinal properties are important in the treatment of +mental illness. The results of the present study are consistent with the results of earlier studies by Mbwayo, et al. (2013), Holomisa (2009), and Bujo (2009), which found that traditional healers tended to regard herbs and animal parts as healing agents in the treatment of mental illness. Also a previous study by Ross (2010) found that traditional healers associate the treatment of mental illness with the use of herbs. Unlike in the case of the present study, Holomisa (2009) and Bujo (2009) also found that minerals are used as healing agents in treating mental illness, while Ross (2010) suggested nutrition and physical therapy. Another study by Atindanbila and Thompson (2011) whose findings differ from the current results found that restraints such as ropes and chains, and sedatives are used in treating mental illness. These methods are used to reduce mobility to patients who are always on the go and provide safety to the patients and those who may potentially be harmed.

The current study revealed that medicine may be administered through lacerations, drinking/eating and bathing. Any medicine given to the patient has to be in contact with the skin or body of that individual in some way. A study like that of Mbwayo, et al. (2013) supports these findings by suggesting that medicines may be taken orally or in the form of a bath. Whilst there were some similar characteristics identified by the previous and the current study, there were also some points of divergence. For example, the previous study by Mbwayo, et al. (2013) found that inhalation is one way for a patient to take medicine.

6.2.4 Challenges faced by traditional healers

The present study found that traditional healers face some challenges that include the following: a) treatment failure of interventions (*mushonga unotadza kurapa*); b) anger (*kutsamwa*); c). jealousy (*godo*); d) concerns by traditional healers around theft of ideas and intellectual property or knowledge by others (*kuba*); and e) discrimination (*rusarura*).

Some participants did acknowledge that there are limitations with regard to their interventions as some clients do not respond positively to some medicines that a traditional healer may have used successfully with another client with a similar problem. The participants also admit that some clients who do not respond positively to their treatment may need to consult elsewhere. The present findings lent support to the results of a previous study by Ngobe (2015) who found that some illnesses are challenging for the traditional healers to deal with. Whilst there were some similar challenges identified by the pervious and the current study, there are some points of divergence. For example, the study by Ngobe found that some traditional healers acknowledged that failure to treat certain conditions was the result of failure by the affected traditional healer to use traditional medicines correctly.

Most of the traditional healers who participated in the present study indicated their willingness to refer patients that they cannot treat to other practitioners. This acknowledgement of treatment failure makes them amenable to collaborative work with their peers and the biomedical practitioners. Based on this, it can therefore be inferred that traditional healers seem to be more concerned about the well-being of the client than the money that they could potentially receive from a client.

The present study revealed that traditional healers regard anger (*kutsamwa*) as one of the challenges in their work. In other words, emotions like anger can negatively affect the effectiveness of a traditional healer. This means that emotions such as anger will cause traditional healers to be unstable which in turn may affect patient safety. Some previous studies by AE-Ngibise, Cooper, Adiibokah, Akpaulu, Lund, Doku, & THE MHAPP RESEARCH PROGRAMME CONSORTIUM (2010), Chan (2008), WHO (2008), Vinorkor (2004) and WHO (2002), have also found that the work of traditional healers is marked by safety concerns. Whilst these studies are in agreement to some extent regarding safety concerns, they do have their differences.

For example a study by Chan (2008) found that non-Western healing practices are said to be failing to ensure quality. Also AE-Ngibise, et al. (2010) found that mostly maltreatment amongst traditional and faith healers was very real. Unlike in the present study, Shizha and Charema (2011) suggested that the work of traditional healers is lacking in terms of hygiene and sanitation which can be improved through training so that they use gloves to examine clients. In an earlier study, Atherton (2007) criticises African traditional healing practices by arguing that it has poor hygiene standards and is imprecise in terms of dosage.

As suggested by Bojuwoye and Sodi (2010), traditional healers need to learn ethical procedures and ensure that they uphold patients' rights. What is implied here is that this kind of work that requires constant interactions with clients and the spiritual world calls for emotional stability.

Some participants did acknowledge that their effectiveness as traditional healers may be negatively affected by their own relatives who may be jealous. These relatives with evil intentions and actions may want to interrupt the connection that has been established between a traditional healer and the ancestral beings.

The implication here is that a traditional healer can only be effective if he/she is forever having constant interaction with the ancestors as these spiritual forces are believed to provide the necessary guidance. The results of the current study are consistent with the findings of a study by Flint (2015) which compared South African and Native American experiences and found that witchcraft is influenced by jealous and the need to bring disrepute to a successful person by bringing about misfortune.

Some of the participants did raise concerns that they are being used by other professionals who interact with them with a view to stealing their ideas. Traditional healers are faced with a dilemma when it comes to sharing information about their practice. For example some traditional healers indicated that they felt used by researchers who would come to them to get information that is later used for the gain of these researchers.

The current study lent support to earlier studies by Wekundah (2012) and Ramsay (2002) which found that traditional healers may fear giving information about their healing practices because they feel that their knowledge may be stolen. The Convention on Biological Diversity (CBD) Secretariat observed that the intellectual property rights (IPR) system did not sufficiently ensure the flow of benefits back to the indigenous and local communities (Chitsike 1998). The results of the current study are consistent with the results of an earlier study by Mposhi, Manyeruke and Hamauswa (2013) which found that Zimbabwe is lagging behind in the establishment of a sound legislative system that would cover the issues of access and benefit sharing for biological resources found in the country. In other words, anyone has access to biological resources as well as indigenous knowledge and can develop products without meaningful recognition of the indigenous communities. In view of these potential IPR infringements, Abbott (2009) suggests that there should be a system put in place, as is the case in China.

Participants reported that they feel discriminated by the authorities, churches and other community members who view their practices as unscientific and evil. These people see nothing good coming from traditional healing. In other words, traditional healers feel that they are not accepted by authorities, churches and some community members who seem to be determined to play down the role and value of traditional healing. Some previous studies have also found that discrimination is a challenge faced by traditional healers (Mbwayo, et al., 2013; Van Niekerk, 2014). For example studies by Summerton (2006) and Wreford (2005) found that collaborative efforts have failed because they have been uni-directional as more Western trained practitioners fail to respect the positive contributions of more traditional practices. In another earlier study, Atindanbila and Thompson (2011) found that traditional healers are being discriminated against since they are perceived by some in Western scientific circles as unscientific. Some members of the biomedical community perceive the traditional healing system as having no sound anatomy and physiology knowledge. Despite this lack of recognition, a considerable number of patients in the developing world utilise the services of both traditional healers and the Western trained health practitioners (Van Niekerk, 2014). This makes it crucial for both systems to find ways to work together in order to benefit the patients.

Participants reported that they feel that the authorities do not have adequate knowledge to assess and pass judgement on their system. These authorities use criteria developed for the biomedical system to judge and disqualify the traditional healing system. The results of the present study are consistent with the results of an earlier study by Chan (2008) which found that non-Western healing practices are said to have no research data and no standardised manufacturing practices. A study by Mposhi et al. (2013) suggest that issues of quality, efficiency and efficacy of traditional medicines have been the main cause for its poor promotion in Zimbabwe's formal health care system. In addition to this, Mapara (2009) suggests that despite the Zimbabwean government recognition of Zimbabwe National Traditional Healers' Association (ZINATHA) being made formal, traditional medical practices have been side-lined from formal incorporation into the country's health care system.

The findings above suggest that authorities tend to use the western epistemological lens to judge and disqualify a system that requires to be understood and judged using a different approach.

6.2.5 Facilitating factors in the work of traditional healers

The study results revealed that factors which facilitate the work of traditional healers are: a) remuneration for work done which includes i) honesty *'kuvimbika'* and ii) affordability of services rendered '*kubhadhara kusingaremere vanhu',* and b) teaching others.

This study discovered that honesty in conducting their work makes people visit and trust traditional healers. The participants emphasised the ethical issue of honesty on their part and also on the part of their clients. Some participants pointed out that they will only accept payment for treatment offered and completed. The results of the present study are consistent with the results of an earlier study by AE-Ngibise, et al. (2010) which found that many traditional healers would normally refer a patient to another healer when they found the condition very difficult to manage, while a few suggested referring the person to a more powerful healer to take over the treatment process. Also a study by Mbwayo, et al. (2013) found that traditional healers refer their patients to other more experienced healers. The above findings suggest that

issues of honesty and fairness are central in traditional healing which indicates that their work is guided by some ethical principles.

Participants stated that they try hard to ensure that what they charge for their services is affordable for their patients. Their payment is negotiated with surety given where there is no money. This present findings lent support to results of a previous study by Mbwayo, et al. (2013) which found that pre-payment was not a condition for treatment as there was allowance for payment to be made post-treatment. This study by Mbwayo and others went on to suggest that the fact that one could pay in instalments and in kind, made the payment arrangements for traditional healing practices more flexible. However Mbwayo et al.'s findings do differ from the current findings by suggesting that there was also fear of spiritual punishment or recurrence of the illness should one fail to honour an oral undertaking to pay. This meant that patients feel compelled to pay for fear of spiritual punishment. In this sense, traditional healers have devised better ways of making the service accessible without sending away poor patients due to lack of money. Treatment from traditional healers shows a perception that the health of an individual is more important than the money. Their patients are treated in a more human and empathic manner, since the traditional healers know how difficult it is to get money at times.

Participants stated that they do value continuous professional development which is acquired mainly through some form of peer education. They feel that those who have knowledge and experience in specific areas help them to broaden their scope of competencies. The results of the present study are consistent with the results of previous studies which found that traditional healers invest time to engage in continuous professional development (Thornton, 2002; van Binsbergen, 1991)

The implication here is that the traditional healers have developed their own system of continuous professional development that is premised on some principles of sharing, trust and peer education.

6.3 Conceptualisation and treatment of associated illnesses by traditional healers

6.3.1 Epilepsy (*pfari*)

6.3.1.1 Types/characteristics of associated illnesses epilepsy (*pfari*)

The results of the present study suggest that the participants do recognise the existence of a distressing condition known as *pfari* which, in Western medicine, could be likened to epilepsy. According to the participants, some of the symptoms displayed by individuals with *pfari* include: a). temporary confusion and formed visual hallucinations (for example, visions of animal-like creatures); b). seizures resulting in non-purposeful movements; and, c). drooling. There appears to be some similarities in terms of the symptoms of epilepsy and what is regarded as *pfari*. For example, in Western medicine and psychology, individuals who suffer from epilepsy display a number of symptoms that, among others include epileptic seizures and altered consciousness (Muircheartaign & Richardson, 2012). In a previous study that focused on the experiences of people living with epilepsy in one South African rural community, Siriba (2014) found that epilepsy is a disease of “falling” and it was observed that cultural understanding influenced the way epilepsy is understood by the participants.

Since the two healing systems (that is, Western and traditional) do offer interventions for people suffering from epilepsy, it is important for the practitioners in the two systems to consider collaborating in order to assist the clients. Studies have indicated that there are a number of factors that hinder collaboration between the two systems. For example Sodi and Bojuwoye (2011) have identified a number of these hindrances. These include epistemological challenges, challenges related to attitudes, abuses, treatment methods and other practice issues as well as research challenges. In view of these hindrances, the two authors point out that there is a need for the two systems to be accommodative as each model of illness and healing is only meaningful when approached from the cultural context of the concerned society.

6.3.1.2 Causes of Epilepsy (*pfari*)

Participants revealed that epilepsy is caused by spiritual and biological factors. The spiritual factors reported include: a) witchcraft (*huroyi*); and b) goblins (*chikwambo/zvishiri*), while the biological factors were only heredity (*chirwere chemhuri*). Participants believed that people with evil intentions may manipulate animal-like creatures to attack those that they intent to harm. These deeds are associated with witchcraft. The results of the present study are consistent with the results of earlier studies by Nyame and Biritwum (1997) and Haddock (1993) which found that in central Africa and Sub-Saharan Africa, epilepsy is attributed to the presence of a lizard in the brain. In this cultural context, the epileptic fits are understood to occur whenever the lizard moves in the brain. Like in the previous studies by Mahommed & Babikir (2013), Mushi, Burton, Mtuya, Gona, Walker and Newton (2012) and Mangena-Netshikweta (2003), the present study found that epilepsy was understood by most participants to be caused by evil spirits (*chikwambo/zvishiri*) and witchcraft (*huroyi*). Even though the previous studies and the current study share similarities on causes, there were also some points of divergence. For example, a pervious study conducted in Malawi by Mushi, Burton, Mtuya, Gona, Walker and Newton (2012) found that experiences such as head injury and birth trauma can cause epilepsy.

Heredity was identified by the participants as one of the possible causes of associated illness. Relatives are believed to pass the condition to their children which makes the condition a family disease. Some previous studies have also found that *pfari* is attributed to heredity (Ogunrin, Adeyekun and Philomene, 2013). For example the study conducted by Ogunrin, et al. (2013) in Nigeria found that all of participants living with epilepsy patients, primarily had generalized seizures and 6 of the 34 gave history of epilepsy in first-degree relations (siblings and parents), 17 reported epilepsy in second-degree relations (uncles, aunts and grand-parents) and 11 reported epilepsy in third-degree relations in Nigeria.

6.3.1.3 Treatment of epilepsy (*Pfari*)

The findings of this study indicate that spiritual forces play a very important role as one of the causal factors of epilepsy (*pfari*). Consequently, the treatment of *pfari* requires some spiritual intervention that according to the participants include: a) pushing away bad spirit (*kusudurudza mhepo*); b) re-directing the evil spirits to afflict a wrong doer (*kudzosera mweya wakaipa kune akawutumira*); and c) inducing the spirit to talk (*kudhonza mhepo kuti itaure*). The present findings lent support to results of previous studies by Mahommed and Babikir (2013) and Mangena-Netshikweta (2003) which found that spiritual intervention is the way to treat epilepsy. The current study specifies that this spiritual intervention has various forms. The first is that the evil spirit can be pushed away by the traditional healers using the medicines and the spiritual instructions from the ancestors. The second one is that the evil spirit can be re-directed to afflict the wrong doer. The last one is that the evil spirit can be induced to talk so that negotiations can be made for it to leave or be re-directed to the wrong doer. Whilst there were some similar treatment methods identified by the previous and the current study, there were also some points of divergence. For example, the study by Mangena-Netshikweta (2003) found that holy water is used by traditional healers to treat epilepsy. Also contrary to the current study, Baskind and Birbeck (2005) found that traditional healers agreed that nothing should be placed in the patient's mouth. They unanimously accepted "blowing smoke up into the nostril" to try to stop the seizure.

The findings above suggest that epilepsy needs spiritual intervention in addition to the medical interventions. The ability of traditional healers to experience some transcendental powers enables them to engage the spiritual forces whilst at the same time maintaining contact with the living.

6.3.2 Sexual dysfunctions (K*usungwa*)

6.3.2.1 Characteristics/types of sexual dysfunctions (k*usungwa*)

Participants in the present study did identify and describe a number of conditions that appear to parallel sexual dysfunctions as understood in Western medicine and psychology. The conditions identified by the participants include the following: a) *kufuratidzwa moyo* (losing sexual interest); b) failure to experience or maintain an erection (*kutadza kumira kwenhengo yemurume*); c) involuntary penis withdrawal (*kudzokera mukati kwenhengo yemurume*); d) ejaculatory incompetence (*kutadza kutunda*); e) infertility (*kupindura nyoka yemudumbu*); and other forms of sexual dysfunction (*kuuraya Chinhu*). Sexual dysfunctions refers to sexual difficulties which may cause the affected individual not to experience any of the following: a) physical pleasure; b) sexual desire; c) arousal or orgasm; or d) inability to conceive.

Participants reported that some people experience sexual problems that are characterised by the sudden loss of interest in sexual activities with a partner. These findings lend support to an earlier study by Goshtasebi, Gandevani, and Foroushani (2011) who found that some people experience diminished or no feelings of sexual interest or desire.

The findings above suggest that though the affected individual may, at the cognitive level want to initiate some sexual activity, such an individual may physically be unable to perform as a result of the dysfunction. It is believed that spiritual intervention may help to restore the individual's desire for sexual activity.

According to some of the participants, an individual may have an erection followed by successful penetration, but may fail to ejaculate during sexual intercourse. A wife is believed to cause this problem through some spiritual powers that will negatively affect the man's ejaculatory efforts. Similar results were reported in a study by Althof, et al. (2006) which indicated that a man may experience the absence of ejaculation during orgasm, known as anejaculation. It is interesting to note that both biomedical and traditional healers do agree on the absence of ejaculation, although they differ on the causes. In the case of the biomedical explanation as reflected in the study by Althof et al, biological and anxiety may be the causes of the ejaculatory problems. However, the participants in the present study attribute the ejaculatory problem to some spiritual problem.

Some participants are of the view that infertility in women can be caused by jealousy or the evil intentions of others. It is understood by the participants that an individual may use spiritual powers to affect the ovary from sending the ovum to the funnel of the oviduct. The current findings are consistent with an earlier study by Aina and Morakinyo (2011) which found that infertility may be caused by a spiritual attack as a female experiences some form of attack by a “spiritual husband”. These findings seem to suggest that infertility is caused by the influence of a spiritual force. However the spiritual attack may differ from one community to another.

It is interesting to note that traditional healers perceive conditions described above to be associated with mental illness. On the other hand, the DSM 5 tends to categorise most of these sexual dysfunctions and problems as mental illness. These conditions include: a) male hypoactive sexual desire disorder; b) female sexual interest/arousal disorder; c) female orgasmic disorder; d) erectile disorder; and e) penetration disorder.

6.3.2.2 Causes of sexual dysfunctions (*kusungwa*)

The findings of the study revealed the following as causes of associated illnesses: a) locking of the sexual organs using a tortoise (*kamba*); b) using a stone and medicine- dwala (*ruware*); and c) using an item and medicine (*hembe kana chipenga nemushonga*). All these causal factors are perceived by the participants to require the skills of a traditional healer to diagnose. Some studies on sexuality conducted in Turkey emphasise the role of cultural aspects in sexuality (Aydin & Gulcat, 2001; Aydin & Gulcat 2004). A study by Aina and Morakinyo (2011) suggested that sexual dysfunctions are caused by witchcraft performed by those with evil intentions. This suggests that sexual problems will not be resolved successfully without the attention of traditional healers.

6.3.2.3 Treatment of sexual dysfunctions

Participants reported that some community members may have some evil intentions to the extent that they may want to make others suffer. They manipulate and mobilise spiritual forces that will remotely affect the person who is the target of these actions. Participants revealed that a plant which is like runner grass is used to treat infertility. The affected person orally takes the prepared medicine. The results of the present study are consistent with the results of earlier studies by Cheikhyoussef, et al., (2011), and Kamatenesi-Mugisha and Oryem-Origa (2005), which found that infertility can be treated using plant material. The results of the present study do suggest that traditional healers use a variety of procedures to treat the other sexual dysfunctions that they have identified. These, among others include the use of local beers, elephant dung, fermented milk and porridge. Even though the present study concurs with some of the previous studies, there are some points of divergence. For example, whilst the current study found that the medicine to treat infertility is administered orally, Cheikhyoussef, et al. (2011) in a study on medicinal plants used by traditional healers in Namibia pointed out that treatment for infertility in can be administered rectally.

The above findings suggest that the participants are of the view that a plant can be used to reverse infertility. These findings also suggest that associated illnesses are treated either by plant or animal parts.

6.4 Concluding remarks

In this chapter, the findings of the present study were discussed in the context of previous studies. As is evident from the findings, the traditional healers interviewed tended to view mental illness to be a serious condition that would be likened to psychotic conditions in Western medicine and psychology. In this cultural context, mental illness is understood to be caused by a number of factors that include witchcraft, ancestral wrath and so forth. A number of methods are used to treat mental illness.

CHAPTER 7
SUMMARY AND CONCLUSION

7.1 Introduction

In the first part of this chapter a summary of the research findings is presented. In this regard, the two key findings (that is, conceptualisation of mental illness and conceptualisation of associated illness) are highlighted. In the second part of the chapter, the implications of the study with regard to health care providers, theory, policy and future research are presented. The third part of the chapter highlights the limitations that are associated with the study.

7.2 Summary of the research findings

7.2.1 Conceptualisation of mental illness

7.2.1.1 Characteristics/types of mental illness

This study was aimed at exploring the characteristics/types of mental illness as experienced by Zezuru Shona traditional healers. The findings suggest that Zezuru Shona traditional healers do not have an elaborate nosological system that recognises a variety of mental illnesses. Instead, they tend to focus more on the description of what could be considered the symptoms rather than giving nosological labels to the conditions.

Participants perceived mental illness as a condition that manifests behaviourally and physically. Behaviourally, the individual with mental illness is undertood to show some disorganised behaviour patterns include the following: inappropriate laughing (*kuseka zvakapfuura mwero*), talking to self (*kutaura wega*), illogical thoughts (*kurotomoka*), derailment (*kurasika pakutaura*), failure to recognise familiar people (*kukanganwa hama dzepedyo*) and tactile sensation (*kufambwa fambwa*). Mentally ill people turn to behave differently from those without mental illness. The physical complains which were mentioned include: headache (*kutemwa nemusoro*), heart palpitations (*kurohwa nehana*), dizziness (kunzwa dzungu)

7.2.1.2 Causes of mental illness

The findings revealed that Zezuru Shona traditional healers perceive mental illness to be caused by both internal and external factors which could be spiritual or biological in nature. Heredity and trauma were understood to be some of the common causes of mental illness. This study revealed a strong view that the external factors- (predominantly, some spiritual forces) play a bigger role. The spiritual forces which cause mental illness include: witchcraft (*huroyi*), avenging spirits (*ngozi*) and the spirits which follow an ancestral spirit (*mweya yakaipa inoteera mudzimu*).

7.2.1.3 Diagnosis and treatment of mental illness

A number of diagnostic and treatment procedures were found to be used by traditional healers. These, among others include: *kushopera* (divination), *girazi* (looking glass), *kurotswa* (using dreams), *mushonga* (medicines) and the treatment of evil spirits. With regard to diagnosis, the ancestors are believed to guide the traditional healers who often use a number of procedures that include divination, looking glass and/or dreams. It was found that some of the treatment procedures are intended to deal with what is understood to be evil spirits. In this regard, the evil spirits can be dealt with by inducing them to talk (*kudhonza mhepo).* Different plant and animal derivates were fount to be used as medicine. In other words, it does appear that there are well defined diagnostic and treatment methods that traditional healers use within their cultural context to deal with mental illness.

7.2.1.4 Challenges and facilitating factors in traditional healers' work

Traditional healers highlighted a number of challenges that are asociated with their work. Emotions such as anger (*kutsamwa*) and jealousy (*godo*) were found to be challenges for some traditional healers. Discrimination (*rusarura*) by Western trained health practitioners was cited as one of the challenges. Other traditional healers identified treatment failure (*mushonga unotadza kushanda*) as one of the challenges.

Though there are challenges associated with their work, traditional healers identified a number of factors that serve as facilitators in ther work. These include a) fair remuneration for work done and b) continuous professional development (*kudzidzisana*).

7.2.2 Conceptualisation of associated illnesses

The present study found that traditional healers identify a few conditions (mainly epilepsy and sexual dysfunctions) that caused considerable distress even though they could not be considered mental illness. Consequently, the researcher has opted to refer to these as associated illnesses. What follows here below is a brief description of each of these two associate illnesses.

7.2.2.1 *Pfari* (epilepsy)

7.2.2.1.1 Characteristics of *pfari* (Epilepsy)

Findings suggest that traditional healers do recognise the existence of a condition of *pfari* which, in Western medicine and psychology, could be regarded as epilepsy. The symptoms of pfari include: a). temporary confusion and visual hallucinations (for example, visions of animal-like creatures); b). seizures resulting in non-purposeful movements; and, c). drooling. *Pfari* has been described to be dominated by behavioural symptoms.

7.2.2.1.2 Causes of *pfari* (Epilepsy)

Participants revealed that epilepsy is caused by spiritual and biological factors. The spiritual factors reported include: a) witchcraft (*huroyi*); and b) goblins (*chikwambo/zvishiri*), while heredity (chirwere chemhuri) was understood to be the biological causal factor.

7.2.2.1.3 Treatment of *pfari* (Epilepsy)

The findings of the study indicate that, the treatment of *pfari* require some spiritual intervention which according to the participants include: a) pushing away bad spirit (*kusudurudza mhepo*); b) re-directing the evil spirits to afflict a wrong doer (*kudzosera mweya wakaipa kune akawutumira*); and c) inducing the spirit to talk (*kudhonza mhepo kuti itaure*).

7.2.2.2 Sexual dysfunctions (K*usungwa*)

7.2.2.2.1 Characteristics/types of sexual dysfunctions (*Kusungwa*)

The conditions identified by the participants include the following: a) *kufuratidzwa moyo* (losing sexual interest); b) failure to experience or maintain an erection (*kutadza kumira kwenhengo yemurume*); c) involuntary penis withdrawal (*kudzokera mukati kwenhengo yemurume*); d) ejaculatory incompetence (*kutadza kutunda*); e) infertility (*kupindura nyoka yemudumbu*); and other sexual dysfunctions (*kuuraya chinhu*).

7.2.2.2.2 Causes of sexual dysfunctions (*Kusungwa*)

A number of items such as plant extracts, fabric and, animal parts are believed to be used by those with evil intentions to cause to cause sexual dysfunctions in others. All these causal factors are perceived by the participants to require the skills of a traditional healer to diagnose.

7.2.2.2.3 Treatment of sexual dysfunctions (*Kusungwa*)

Traditional healers highlighted that sexual dysfunctions are treated by plant parts and animal droppings. These treatment methods include: a) unlocking (*kusunungura*); b) treatment of infertility (*kusimikira*); and c) use of elephant's dung (*ndove yenzou*). Ancestral spirits are believed to constantly guide the traditional healer in treating the sexual dysfunctions.

7.3 Implications of the findings

7.3.1 Implications for those who offer help to the mentally ill

The study suggest that traditional healers continue to provide a culturally meaning service to their clients who present with mental illness. In view of this, it is imperative that there is a need for Western trained health care providers to engage traditional healers in a dialogue to explore possibilities of collaboration between the traditional and Western healing systems. Such a collaborative engagement will hopefully result in better treatment outcomes for patients suffering from mental illness and other associated conditions.

There is need to constantly educate Western health care providers on African traditional healing systems in order to bridge the gap between biomedical and African traditional healing systems.

7.3.2 Implication of the findings to the Afrocentric perspective

In line with the Afrocentric perspective, the present study located traditional healers at the centre by allowing them to describe, in their own way, their understanding of mental illness. In other words, the traditional healers were the centre of information gathering as they explained the characteristics, causes and treatment of mental illness and associated illnesses. This concurs with the Afrocentric framework which calls for Africans to be the centre of defining and explaining phenomenon that affect them.

The research revealed that mental illness and the associated illnesses are culturally defined and that causes thereof are also meaningful if understood from the perspective of a particular culture. This was illustrated by the traditional healers' common view that spiritual factors influence the genesis, course, diagnosis, treatment and prevention of mental illness and the associated conditions of ill health. In contrast to the biomedical model which states that mental illness is predominantly a result of biological and social factors, traditonal healers are of the view that spiritual factors, are also involved in causing, maintaining and treating mental illness. Based

on these observations, it is suggested that traditional healers should be considered as a valuable mental health care resource in Zimbabwe.

7.3.3 Implication of the findings for policy and programs

Based on the findings of the present study, it can be argued that there is a need to implement culturally sensitive mental health policies. In this regard, there is a need for the Ministry of Health and Child Welfare to start engaging traditional healers with a view to bringing them on board.

The government needs to develop policies which will protect intellectual property ownership of traditional healers' knowledge. Such a move could encourage traditional healers to open up and to share their knowledge and skills with Western trained health practitioners and vice versa.

7.3.4 Implications of the findings for future research

Given the role that spirituality seems to play in the treatment of mental illness, there is a need for more studies to understand how this aspect can promote mental well being in individuals and communities. Studies should also be conducted to explore models of collaborations between traditional healers and Western trained health care practitioners in mental health promotion.

7.4 Limitations of the study

The present study is not without shortcomings. What follows is a presentation of a number of limitations asscoaited with the study. First, the size of the sample for the study is small. This means that the findings of this study cannot be generalised to represent all Zezuru Shona speaking traditional healers in Zimbabwe. The conceptualisation of mental healers by the few traditional healers drawn from the Zezuru community can therfore not be seen to be representative of the views of all the traditional healers in Zimbabwe. However the narrative of this study can be considered to be a legitimate voice of some traditional healers in Goromonzi District. Second, the gender distribution was another limitations since the sample was heavily

skewed in favour of male traditional healers (male = 9; female = 1). This might mean that the female voice in the conceptualisation of mental illness may have been muted. To mitigate against this limitation, future studies might need to involve more female traditional healers so as to obtain a balanced gender view on mental illness and the associated illnesses. This means that some traditional healers may not have revealed all that they know about the conceptualisation and treatment of mental illness. Researchers in furture studies may need to consider involving traditional healers as co-researchers to mitigate against this limitation. Fourth, the interviews were conducted in Shona and were later translated into English by a language expert. This process may have resulted in some of the cultural nuances that are embedded in language being lost in the process of transforming the data from one language to another.

REFERENCES

Abbo, C. (2010). *Profiles and outcome of traditional healing practices for severe mental illnesses in two districts of Eastern Uganda (*Unpublished PhD thesis). Makerere University, Kampala, Uganda

Abbo, C. (2011). Profiles and outcome of traditional healing practices for severe mental illnesses in two districts of Eastern Uganda. *Global Health Action*, 4, 7117.

Abbo, C., Ekblad, S., Waako, P., Okello, E., Muhwezi, W., & Musisi, S. (2008). Psychological distress and associated factors among the attendees of traditional healing practices in Jinja and Iganga districts, Eastern Uganda: a cross-sectional study. *International Journal of Mental Health Systems*, 2, 16.

Abbott, R. (2009). Religious fundamentalism and mental illness: a group analytic exploration. *Group Analysis*, 42(1), 47-61.

Abiodun, O. (1995). Pathways to mental health care in Nigeria. Psychiatric Services, 46(8), 823-26.

Abraham, C. (2007). Don't knock them: without the help of traditional healers and local medicines, managing Africa's AIDS crisis could be impossible. *New Scientist*, 194, 22.

AE-Ngibise, K., Cooper, S., Adiibokah, E., Akpalu, B., Lund, C., Doku, V., & The Mhapp research programme consortium. (2010). 'Whether you like it or not people with mental problems are going to go to them': A qualitative exploration into the widespread use of traditional and faith healers in the provision of mental health care in Ghana. *International Review of Psychiatry*, 22 (6), 558–567.

Aina, O. F., & Morakinyo, O. (2011). Culture–bound syndromes and the neglect of cultural factors in psychopathologies among Africans. *African Journal of Psychiatry*, 4, 278-285.

AIDS InfoNet. (2008). *Native American Traditional Healing: Fact Sheet 708*. Retrieved from http://www.aidsinfonet.org/fact_sheets/view/708#WHAT_IS_NATIVE_AMERICAN_TRADITIONAL_HEALING__

Akomolafe, A. C. (Undated). *Decolonizing the notion of mental illness & healing in Nigeria, West Africa.* Retrieved from http://www.indigenouspsych.org/Interest%20Group/Decolonizing%20the%20notion%20of%20mental%20illness%20and%20healing%20in%20Nigeria.pdf

Althof, S. E., O' eary, M. P., Cappelleri, J. C., Crowley, A. R., Tseng, L. J., &Collins, S. (2006). Impact of erectile dysfunction on confidence, self-esteem and relationship satisfaction after 9 months of sildenafil citrate treatment. *Journal of Urology*, 176(5), 2132-2137.

American Psychiatric Association. (2013). *Diagnostic and Statistical Manual of Mental Disorders, 5th edition*. Arlington, VA: American Psychiatric Association.

American Psychiatric Association. (2015). *APA Dictionary of Psychology*. 2nd Edition. Washington DC. American Psychiatric Association.

Appiah-Poku, J., Laugharne, R., Mensah, E., Osei, Y., & Burns, T. (2004). Previous help sought by patients presenting to mental health services in Kumasi, Ghana. *Social Psychiatry Psychiatric Epidemiology*, 39, 208–211.

Asante, M.K. (1987). *Afrocentricity* (3rd ed.)*.* Trenton: Africa World Press.

Asante, M.K. (2003). *Afrocentricity: The theory of social change (revised and expanded)*. Chicago, Illinois. African American Images.

Atherton, K. (2007). *Holistic healing.* Pindari Herb Farm. Retrieved from http://pindariherbfarm.com/healing/holiheal.htm

Atindanbila, S., & Thompson, C. H. (2011). The Role of African Traditional Healers in the Management of Mental Challenges in Africa. *Journal of Emerging Trends in Educational Research and Policy Studies (JETERAPS)*, 2(6), 457–464.

Aydin, H, H. & Gulcat, Z. (2001). Turkey (Türkiye Cumhuriyeti) (The Republic of Turkey). In Francoeur, R. T. & Noonan, R. J, Editors. *The International Encyclopedia of Sexuality*, vol. 4 (pp 602-638). New York-London: Continuum.

Aydin, H., & Gulcat, Z. (2004). Turkey (Türkiye Cumhuriyeti) (The Republic of Turkey), In Francoeur, R. T., & Noonan, R. J, editors. *The International Encyclopedia of Sexuality* (pp. 1054-1071), 2nd Ed. New York-London: Continuum.

Babbie, E. (1995). *The practice of social research* (7th ed.). Belmont, CA: Wadsworth.

Babbie, E. (2001). *The Practice of Social Research*. 9th ed. Belmont: Wadsworth.

Barlow, D. H., & Durand, V. M. (2005). *Abnormal psychology: An integrative Approach* (4th ed.). Pacific Grove: Brooks/Cole.

Baskind, R., & Birbeck, G. (2005). Epilepsy Care in Zambia: A Study of Traditional Healers. *Epilepsia*, 46(7), 1121–1126.

Bernard, H. R. (2002). *Research Methods in Anthropology*. Third edition ed. Califonia: AltaMira Creek.

Bieser, M. (1991). *A study on depression among traditional Africans, urban North Americans and south East Asian refugees*. In Kleinman & Good (Eds), Culture and depression. California. University of California Press.

Bojuwoye, O. (2005). Traditional healing practices in Southern Africa: Ancestral spirits, ritual ceremonies and holistic healing. In R. Moodley & W. West (Eds.), *Integrating traditional practices into counseling and psychotherapy* (pp.55-65). Thousand Oaks, CA: Sage.

Bojuwoye, O. and Sodi, T. (2010).Challenges and opportunities to integrating traditional healing into counseling and psychotherapy. *Counseling Psychology Quarterly, 23(3),* 283-296.

Bourdillon, M. F. (1975). “Themes in the Understanding of Traditional African Religion.” *Journal of Theology for Southern Africa*, 10, 71-87.

Bourdillon, M. F. (1996). *"Shona." Encyclopedia of World Cultures*. Encyclopedia.com. Retrieved from <http://www.encyclopedia.com>.

Bower, P., Gilbody, S., Richards, D., Fletcher, J., & Sutton, A. (2006). Collaborative care for depression in primary care. Making sense of a complex intervention: systematic review and meta-regression. *British Journal of Psychiatry*, 189, 484-493.

Boyomi, Z. A. (2011). *Incorporation of traditional healing into counseling services in tertiary institutions: Perspectives from a selected sample of students, psychologists, healers and student management leaders at the University of KwaZulu-Natal.* University of KwaZulu-Natal. (Unpublished masters' research).

Bujo, B. (2009). Ecology and Ethical Responsibility from an African Perspective. In: Murove MF, ed. African Ethics: An Anthology of Comparative and Applied Ethics. Scottsville: *University of KwaZulu-Natal Press*, 281-297.

Burns, H., & Grove, S. K. (2007). *Understanding nursing research: building an evidence-based practice*. 4th ed. Texas. Arlington.

Butcher, J. N., Mineka, S., & Hooley, J. M. (2010). *Abnormal psychology*. (14th ed.). Boston: Allyn & Bacon.

Cambray, J., & Carter, L. (eds.), (2004) .Analytical Psychology: Contemporary Perspectives in Jungian Analysis, New York: Brunner-Routledge.

Campbell, S. S. (1998). *Called to heal, traditional healing meets modern medicine in Southern Africa today*. Cape Town: Zebra Press.

Campbell-Hall, V., Petersen, I., Bhana, A., Mjadu, S., Hosegood, V., Flisher, A.J., & MHaPP Research Program Consortium. (2010). Collaboration between traditional practitioners and primary health care staff in South Africa: Developing a workable partnership for community mental health services. *The Journal of Transcultural Psychiatry*, 47, 610-628.

Carpenter, D. R. (2007). Phenomenology as method. In H. J. Streubert & D. R. Carpenter (Eds.), *Qualitative research in nursing: Advancing the humanistic imperative* (pp. 75-99). Philadelphia, PA: Lippincott.

Castellano, D. J. (2011*). Critique of humanistic psychotherapy*. Retrieved from http://www.arcaneknowledge.org

Chan, M. (2008). *Address at the WHO congress on traditional medicine, at Beijing*, People's Republic of China, 7 November, 2008.

Chavunduka, G. L. (1998). *The Professionalization of Traditional Medicine in Zimbabwe*, Harare. ZINATHA.

Chavunduka, G. L. (2001).*The African Religion in Zimbabwe To-Day*. Harare: Munster.

Cheikhyoussef, A., Shapi, M., Matengu, K., & Ashekele, H. M. (2011). Ethnobotanical study of indigenous knowledge on medicinal plant use by traditional healers in Oshikoto region, Namibia. *Journal of Ethnobiology Ethnomedicine,* 7, 10, 1-11.

Chibanda, D., Mesu, P., Kajawu, L., Cowan, F., Araya, R., & Abas, M. A. (2011). Problem-solving therapy for depression and common mental disorders in Zimbabwe: piloting a task-shifting primary mental health care intervention in a population with a high prevalence of people living with HIV. *BMC Public Health*, 26(11), 828.

Chipfakacha, V. (1997). STD/HIV/AIDS knowledge, beliefs, and practices of traditional healers in Botswana. *AIDS Care*, 9, 417–425.

Chitsike, L. T. (1998). Indigenous Knowledge, Intellectual Rights and Development, Sui-generis Legislation Series. *Community Technology Development Trust (CTDT)*, 2-8.

Collins, P. Y., Patel, V., Joestl, S. S., March, D., Insel,T. R., & Daar, A. S. (2011). Grand challenges in global mental health. *Nature*, 475(7354), 27–30.

Colman, A. M. (2001). *Oxford Dictionary of Psychology.* New York. Oxford University Press.

Corey, G. (2009). *Theory and practice of counselling and psychotherapy* (8th ed.). Belmont, CA: Brooks/Cole.

Crawfod, T. A., & Lipsedge, M. (2004). Seeking help for psychological distress: The interface of Zulu traditional healing and Western biomedicine. *Mental Health Religion and Culture*, 7(2), 131-149.

Creswell, J. W. (1998). *Qualitative inquiry and research design: Choosing among five traditions.* Thousand Oaks, CA: Sage.

Dobson, K. S., & Dozois, D. J. (2010). *Historical and philosophical bases of the cognitive- Behavioural therapies*. In K. S. Dobson (Ed.), Handbook of cognitive- behavioural therapies (3rd ed., pp. 3-38). New York. Guilford Press.

Douglas, H., & Douglas, C. (2010). *Cultural Strategy.* Oxford University Press.

Durrheim, K. (2006). *Research design*. In Terre Blanche, M., Durrheim, K. & Painter, D. Research Applied methods for Social Sciences. In Practice 2nd Edition. Cape Town. University of Cape Town Press

Elder, S. (2009). *Sampling methodology*. Geneva. International Labour Organization.

Farooq, S., Large, M., Nielssen, O., & Waheed, W. (2009). The relationship between the duration of untreated psychosis and outcome in low-and-middle income countries: a systematic review and meta-analysis. *Schizophrenia Resume*, 109(1-3), 15-23.

Fernando, S. (2003). *Cultural Diversity, Mental Health and Psychiatry*. London. Brunner Routledge.

Flint, A. (2015). Traditional Healing, Biomedicine and the Treatment of HIV/AIDS: Contrasting South African and Native American Experiences. *International Journal of Environmental Research and Public Health*, 12, 4321-4339.

Fossey, E., Harvey, C., Mcdermott, F., & Davidson, L. (2002). Understanding and evaluating qualitative research. *Australian and New Zealand Journal of Psychiatry*, 36, 717–732.

Foulkes, J. R. (1992). Traditional health workers (letter). *Tropical Doctor*, 22, 121–122.

Frank, A. (2009). *The Constant Fire: Beyond the Science vs. Religion Debate*, 1st edition.

Freud, S. (1933). *New introductory lectures on psychoanalysis*. London: Hogarth Press and Institute of Psycho-Analysis.

Freud, S. (1940). An Outline of Psycho-analysis. *Standard Edition*, 23, 144–207.

Gater, R., De Almeida, E., Sousa, B., Barrientos, G., et al. (1991). The pathways to psychiatric care: a crosscultural study. *Psychological Medicine*, 21, 761–74.

Gelfand, M. (1959). *Shona Ritual*. Cape Town, Juta & Co. Limited.

Gelfand, M. (1965). *The Witch Doctor*, London: Harvill Press.

Gelfand, M. (1982). *The Spiritual Beliefs of the Shona*. Gweru, Mambo Press.

Gilbert, P., Allan, S., & Goss, K. (1996). Parental representations, shame, interpersonal problems and vulnerability to psychopathology. *Clinical Psychology and Psychotherapy*, 3, 23-34.

Girma, E., & Tesfaye, M. (2011). Illnesses in Southwest Ethiopia: A hospital based study. *BioMedical Central Psychiatry*, 11, 138.

Glesne, C., & Peshkin, A. (1992). *Becoming qualitative researchers: An introduction*. White Plains: Longman.

Golafshani, N. (2003). Understanding Reliability and Validity in Qualitative Research. *The Qualitative Report*, 8(4), 597-607.

Goldberg, A. E. (2011). Corpus evidence of the viability of statistical pre-emption. *Cognitive Linguistics*, 22, 131-153.

Goshtasebi, A., Gandevani, S. B., & Foroushani, A. R. (2011). Prevalence of Sexual Dysfunctions: A Systemic Approach. *Sexual Dysfunction- Special Issues*. Retrieved from http://cdn.intechopen.com/pdfs-wm/25429.pdf

Greeff, M. (2005). *Information collecting: Qualitative Research Designs*. In De Vos, A. S, Strydom, H., Fouche, C. B & Delport, S. S. L. Research at Grassroots. Pretoria. Van Schaik Publushers.

Groenewald, T. (2004). A phenomenological research design illustrated. *International Journal of Qualitative Methods*, 3(1). Retrieved from http://www.ualberta.ca/~iiqm/backissues/3_1/pdf/groenewald.pdf

Haddock, E. P. (1993). Neurological disorder in Tanzania. *Journal for Health*, 68(9), 112-118.

Hall, G. C., & Maramba, G. G. (2001). In search of cultural diversity: recent literature in cross –cultural and ethnic minority psychology. *Cultural Diversity and Ethnic Minority Psychology*, 7(1), 12-26.

Heather, P., Duffy, M. H., & Sharer, M. (2012). *"There is no health without mental health": Mental health and HIV service integration in Zimbabwe: Situational analysis*. Arlington, VA: USAID's AIDS Support and Technical Assistance Resources, AIDSTAR-One, Task Order 1. Retrieved from http://aidstarone.com/sites/default/files/AIDSTAR-One_SituationAnalysis_HIV-MentalHealth_Zimbabwe.pdf

Helwig, D. (2009). *Traditional African medicine.* Encyclopaedia of Alternative Medicine. Retrieved from http://findarticles.com/p/articles/mi_g2603/is_0007/ai_2603000708

Herman, C. G. (1996). *Culture, health and illness: An introduction for health professionals*. Boston. Butterworth Heinemann.

Hesse-Biber, S. N. (2010). *Mixed methods research: Merging theory with practice*. New York. The Guilford Press.

Hoepfl, M. C. (1997). Choosing qualitative research: A primer for technology education researchers. *Journal of Technology Education*, 9(1), 47-63.

Holloway, F. (1997). The assessment and management of risk in psychiatry: can we do better? *Psychiatric Bulletin*, 21, 283–285.

Holomisa, S. P. (2009). *According to tradition: A cultural perspective on current affairs*. Somerset West, South Africa: Essential Books.

Hycner, R. H. (1999). *Some guidelines for the phenomenological analysis of interview data.* In A. Bryman, A., and Burgess, R. G. (Eds.), Qualitative

research (Vol 3., pp.143-164). London: Sage.

Jackson, S. W. (1991). Acedia the sin and its relationship to sorrow and Melancholia. In Kleinman, A & Good, B. *Culture and depression: Studies in the Anthropology and Cross Cultural Psychiatric of Affect and Disorder*. California. University of California Press

Jung, C. G., et al. (1964). *Man and his Symbols*, New York, N.Y.: Anchor Books, Doubleday.

Kamatenesi-Mugisha, M., & Oryem-Origa, H. (2005). Traditional herbal remedies used in the management of sexual impotence and erectile dysfunction in western Uganda. *African Health Science*, 5, 40-49.

Kaplan, H. I. & Sadock's, B. J. (2007). *Synopsis of Psychiatry: Behavioural Sciences/Clinical Psychiatry*. Tenth Edition. Philadelphia. Lippincott Williams & Wilkins

Karimi, S. & Eschenuer, A. (2006). We Are Therefore I Am: A Psycho-Cosmos Counselling Model for Black Africans. *International Journal for the Advancement of Counselling.* Retrieved from: www.citeulike.org/klu-adco-76-

Kelly, K. (2006). From encounter to text: Collecting data in qualitative research. In Terre Blanche, M., Durrheim, K. & Painter, D. *Research Applied methods for Social Sciences. In Practice 2nd Edition*. Cape Town. University of Cape Town Press.

Kennedy, M. (2006). *A Guide to Interview Guides*. Retrieved from https://www.msu.edu/user/mkennedy/digitaladvisor/Research/interviewing.htm

Kihlstrom, J. F. A. (1999). Tumbling ground for whimsies? *Contemporary Psychology,* 44, 376–378.

Kolb, B., &, Wishaw, I. (2009). *Fundamentals of Neuropsychology*. (6th, ed.). New York: Worth.

Komla, T. (1997). Traditional Medicine in Contemporary Ghana: A Public Policy Analysis. *Social Science and Medicine*, 45(7), 1065-1094.

Koptoff. (2010). *Ancestors as elders in Africa*. Retrieved from: http://lucky.ukc.ac.za

Kroeber, A. L. (1952). The Nature of Culture. Vol. 437. Chicago: University of Chicago Press; 1952. *Psychosis or Social Sanction*; pp. 310–19

Kurihara, T., Kato, M., Reverger, R., Gusti, Rai Tirta., & Kashima, H. (2005). Never-treated patients with schizophrenia in the developing country of Bali. *Schizophrenia Response*, 15, 79(2-3), 307-313.

Kurihara, T., Kato, M., Reverger, R., & Tirta, I. G. (2006). Beliefs about causes of schizophrenia among family members: a community-based survey in Bali. *Psychiatry Services*, 57(12), 1795-1799.

Kvale, S. (2006). Qualitative Inquiry: Dominance Through Interviews and Dialogues. *Qualitative Inquiry*, 12, 480.

Last, M., & Chavunduka, G. L. (1986). *Professionalisation of African Medicine*. Manchester, Manchester University Press.

Lauer, Q. (1958). *Phenomenology: Its genesis and prospects*. New York: Harper.

Leighton, A. H., & Hughes, J. M. (2005). Cultures as a Causative of Mental Disorder. *The Milbank Quarterly, A Multidisciplinary Journal of Population Health and Policy,* 83(4), 1–22.

Levers, L. L. (2006). Samples of indigenous healing: The path of good medicine. *International Journal of Disability, Development and Education*, 53(4), 479-488.

Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic Inquiry.* Newbury Park, CA: Sage Publications.

Lincoln, Y. S., & Guba, E. G. (1987). Fourth generation evaluation. In D. J. Palumbo (Ed.). *The politics of program evaluation* (pp. 202-204). Newbury Park, CA. Sage.

Kline, P. (1989). Objective tests of Freud's theories. *Psychology Survey*, 7, 127-45.

Llosa, A. E., Ghantous, Z., Souza, R., Forgione, F., Bastin, P., Jones, A., Antierens, A., Slavuckij A., & Grais R. F. (2014). Mental disorders, disability and treatment gap in a protracted refugee setting. *British Journal of Psychology*, 204(3), 208-213.

Lopez, A. D., Mathers, C. D., Ezzati, M., Jamison, D. T., & Murray, C. J. L. (2006). Global and regional burden of disease and risk factors, 2001: systematic analysis of population health data. *The Lancet*, 367(9524), 1747-1757.

Louw, K., Bentley, J. M., Sorsdahl, K., & Adnams, C. M. (2013). Prevalence and patterns of medication use in children and adolescents with autism spectrum disorders in the Western Cape, South Africa. *Journal of Child and Adolescent Mental Health*, 25(1), 69-79.

Kramer, U. (2010). Coping and defence mechanisms: What's the difference? Second act. *Psychology and Psychotherapy: Theory, Research and Practice*, 83(2), 207-221.

Lythcott, J., & Duschl, R. (1990). Qualitative research: From methods to conclusions. *Science Education*, 74, 449-460.

Machinga, M. (2011). *Religion, Health, and Healing in the Traditional Shona Culture of Zimbabwe. Practical matters*. Retrieved from http://practicalmattersjournal.org/wpcontent/uploads/2015/09/19_Machinga_Shona_FINAL.pdf

Magaisa, A. T. (2003). *Knowledge and power: Law, politics and socio-cultural perspective on the protection of traditional medical knowledge systems in Zimbabwe.* The University of Nottingham. (Unpublished).

Mahommed, I. N., & Babikir, H. E. (2013). Traditional and spiritual medicine among Sudanese children with epilepsy. *Sudanese Journal of Paediatrics*, 13(1), 31-37.

Maiello, S. (2008). Encounter with traditional healers Western and African therapeutic approaches in dialogue. *Journal of Analytical Psychology*, 53, 241-260.

Mangena-Netshikweta, M. L. (2003). Perceptions about epilepsy in the Limpopo province of the republic of South Africa. *Curationis*, 51-56.

Map of Zimbabwe showing Goromonzi district. (n.d). Retrieved from (https://en.wikipedia.org/wiki/Mashonaland_East_Province)

Mapara, J. (2009). Indigenous Knowledge Systems in Zimbabwe: Juxtaposing Post-colonial Theory. *The Journal for Pan African Studies,* 3(1), 139–155.

Marchionini, G., & Teague, J. (1987). Elementary students' use of electronic information services: An exploratory study. *Journal of Research on Computing in Education*, 20, 139–155.

Margitics, F. (2009). *Handbook of New Spiritual Consciousness: Theory and Research,* Hauppauge, NY: Nova Science Publishers.

Mash, E. J., & Wolfe, D. A. (2010*). Abnormal child psychology* (4th ed.). Belmont: Wadsworth.

Mazabaum, M. (2006). *Research methodology and statistics 2006*. Johannesburg. Boston City Campus.

Mazama, A. (Ed.). (2003). *Afrocentric paradigm.* Trenton, NJ. African Word Press.

Mazuru, M., & Nesbeth, G. (2013). HIV and AIDS, globalisation and the Shona Indigenous knowledge systems: the impact of HIV and AIDS on the Shona culture. *Greener Journal of Social Sciences*, 3(4), 171–179.

Mbwayo, A. W., Ndetei, D. M., Mutiso, V., & Khasakhala, L. I. (2013). Traditional healers and provision of mental health services in cosmopolitan informal settlements in Nairobi, Kenya. *African Journal of Psychiatry*, 16, 134–140.

Mckay, G. C. (2010). *Journey of an American Sangoma*. Retrieved from www.ancestralwisdom.com

Merriam, S. B. (1995). What can you tell from an N of 1?: Issues of validity and reliability in qualitative research. *PAACE Journal of Lifelong Learning*, 4, 51-60.

Merriam, S. B. (1998). *Qualitative Research and Case Study Applications in Education. Revised and Expanded from" Case Study Research in Education."* Jossey-Bass Publishers, 350 Sansome St, San Francisco, CA 94104.

Mkabela, Q. (2005). Using the Afrocentric method in researching indigenous African culture. *The Qualitative Report*, 10, 178-189.

Mkize, D. L. (2003). Towards an afrocentric approach to psychiatry. *South African Journal of Psychology,* 9(1), 3-6.

Mkhize, N. (12-13 April, 2012). *Culture, mental health & indigenous mental health practice.* Paper presented at National Mental Health Summit, Saint George Hotel. Gauteng.

Monteire, N. M., & Wall, D. J. (2011). African dance as healing modality throughout the diaspora: The use of ritual and movement to work through trauma. *The Journal of Pan African Studies,* 4(6), 234-252.

Moodley, R. (2005). Shamanic performances: Healing through magic and the supernatural. In R. Moodley & W. West (Eds.), *Integrating traditional practices into counseling and psychotherapy* (pp. 2-38). Thousand Oaks, CA: Sage.

Moustakas, C. (1994*). Phenomenological research methods.* Thousand Oaks, CA: Sage.

Mposhi, A., Manyeruke, C., & Hamauswa, S. (2013). Importance of patenting traditional medicines in Africa: the case of Zimbabwe. *International Journal of Humanities and Social Sciences,* 3(2), 236–246.

Msotho, N. L., Low, D. ., Calitz F. J., & Estehuyse, K. G. F. (2008). Depression among Sesotho speakers in Mangaung, South Africa. *African Journal of Psychiatry*, 35-43.

Muchinako, G. A., Mabvurira, V., & Chinyenze, P. (2013). Mental illness and the Shona people of Zimbabwe, some key issues. *International Journal of Advanced Research in Management and Social Sciences*, 2(3), 160-172.

Mufamadi, J. (2001). *A group of traditional healers' perceptions of and approaches to the treatment of mental illness.* A paper presented at the indigenous knowledge conference. University of Saskatchewan: Saskatoon, Canada. University of Saskatchewan.

Mufamadi, J., & Sodi, T. (2010). Notions of mental illness by Vhavenda traditional healers in Limpopo province South Africa. African Journal of Indigenous Knowledge Systems, 9(2), 253-264.

Muircheartaign, J. O., & Richardson, M. P. (2012). Epilepsy and frontal lobes. *Cortex, 48,*144-155.

Mulhauser, G. (2011). *Counselling resource: An introduction to existential Counselling*. Retrieved from http://counsellingresource.com/lib/therapy/types/history.

Mutwa, V. C. (2003). *Zulu Shaman: Dreams, Prophecies and Mysteries*. Vermont. Destiny Books.

Mushi, D., Burton, K., Mtuya, C., Gona, J. K., Walker, R., & Newton, C. R. X. (2012). Perceptions, social life, treatment and education gap of Tanzanian children with epilepsy: A community based study. *Epilepsy and Behaviour*, 23, 224-229.

Mzimkulu, J, & Simbayi, L. (2006). Perspectives and practices of Xhosa speaking African traditional healers when managing psychosis. *International Journal of Disability, Development and Education*, 53, 413-417.

Nelms, L. W. & Gorski, J. (2006). The Role of the African Traditional Healer in Women's Health. *Journal of Trans Cultural Nursing*, 17, 184-189.

Ngobe, A. J. (2015). *Swati traditional healers' conceptualisation of causes and treatment of mental illness*. Sovenga. University of Limpopo. (Unpiblished masters' research).

Ngoma, M., Prince., and Mann, A. (2003). Common mental disorders among those attending health clinics and traditional healers in urban Tanzania. *British Journal of Psychiatry*, 183(4), 349-355.

Nkatazo, L. (2010). *80% of Zimbabweans use traditional medicines*: Report. The Zimbabwean, 11 March, 5.

Nwoko, K. C. (2009). Traditional psychiatric healing in Igbo land, Southeastern Nigeria. *African Journal of History and Culture*, 1(2), 36-43.

Nyame, P. K., & Biritwum, R. B. (1997). Epilepsy knowledge, attitude and practice in a literature urban population Accra, Ghana. *West Africa Journal of Medicine*. 16(3), 139- 145.

Ogbebor. O. (30 december 2011). *The value of indigenous knowledge system based on literature review.* Retrieved from http://osarome.blogspot.com/2011/12/write-on-value-of-indigenous-knowledge.html#!/2011/12/write-on-value-of-indigenous-knowledge.html

Ogana, W., Ngidi, T., & Zulu, P. (2009). *An assessment of the effectiveness and desirability of an indigenous health service at the University of KwaZulu-Natal.* Research document at the Howard College campus of the University of KwaZulu-Natal: Durban.

Ogunrin, O. A., Adeyekun, A., & Adudu-Philomena, A. (2013). Etiologies of epilepsy and health-seeking patterns with epilepsy in a resource poor setting: Analysis of 342 Nigerian African. *Epilepsy and Behaviour*, 22, 572-576.

Organization of African Unity. (2001). *Assembly of heads of state and government. Thirty-seventh ordinary session/ fifty ordinary session of the AEC*. 9-11 July, Lusaka.

Palthe, W. (1936). Psychiatry and Neurobiology in the Tropics. In C. D. deLangen & A. Lichtenstein (eds.). *A clinical textbook of Tropical Medicine* (pp. 325-347). Batavia. G. Koff & Co.

Palys, T. (2008). *Purposive sampling*. In L. M. Given (Ed.). The Sage Encyclopaedia of Qualitative Research Methods. (Vol.2, pp. 697-8). Sage: Los Angeles.

Pandey, S. C., & Patnaik, S. (2014). Establishing reliability and validity in qualitative inquiry: A critical examination. *Journal of Development and Management Studies XISS*, *Ranchi*, 12(1): 5743-5753

Patel, V. (2001). Cultural factors and international epidemiology. *British Medical Bulletin*, 57, 33–45.

Patel, V., & Kleinman, A. (2003). Poverty and common mental disorders in developing countries. *Bulletin of World Health Organization*, 81, 609-615.

Patel, V., Abas, M., Broadhead, J., Todd, C., & Reeler, A. (2001). *Depression in developing countries: lessons from Zimbabwe. In British Medical Journal,* 24,322(7284), 482-484.

Patel, V. (2011). Traditional healers for mental health care in Africa Vikram. *Global Health Action 2011*, 4: 7956-7958.

Patel, V., Simunyu, E., Gwanzura, F. (1997). The pathways to primary mental health care in high-density suburbs in Harare, Zimbabwe. *Social Psychiatry and Psychiatric Epidemiology*, 32(2), 97-103.

Patton, M. Q. (1990). *Qualitative Evaluation and Research Methods* (2nd ed.). Newbury Park, CA: Sage Publications.

Patton, M. Q. (2002). *Qualitative Research and Evaluation Method*. London: SAGE Publications.

Percival, R. S. (1993). "Is Jung's Theory of Archetypes Compatible with Neo-Darwinism and Sociobiology?" *Journal of Social and Evolutionary Systems*, 16.4.

Pfeifer, S. (1999). Demonic attributions in nondelusional disorders. *Psychopathology*, 32, 252-259.

Pretorious, E. (2004). *Complementary/Alternative Traditional Health Care in South Africa. Health and Health Care in South Africa*. Pretoria. Van Schaik Publishers.

Price, M. (2011). Existential-humanistic psychologists hope to promote the idea that therapy can change not only minds but lives. *Monitor on Psychology,* 42(10), 58.

Prince, M., Patel, V., Saxena, S., Maj, M., Maselko, J., Phillips, M.R., & Rahaman, A. (2007). No health without mental health. *Lancet*, 370, 859–877.

Pringle, J., Drummond, J., McLafferty, E., & Hendry, C. (2011). Interpretative phenomenological analysis: A discussion and critique. *Nurse Researcher*, 18, 20-24.

Puckree, T., Mkhize, M., Mgobhozi, Z., & Lin, J. (2002). African traditional healers: What health care professionals need to know. *International Journal of Rehabilitation Research*, 25, 247–251.

Quinn, N. (2007). Beliefs and community responses to mental illness in Ghana: The experiences of family carers. *International Journal of Social Psychiatry*, 53, 175–188.

Ramsay, S. (2002). Traditional medicine gets healthy recognition. *Lancet*, 359, 1760.

Refugee Review Tribunal Australia (2009). *RRT Research Response- on Zimbabwe mental illness-Social attitudes-treatment programs-support groups-Legal provision*. Retrieved from http://www.refworld.org/pdfid/4b6fe323d.pdf

Ronald, C. (2011). Interviewing the investigator: strategies for addressing instrumentation and research bias concerns in qualitative research. *The Qualitative Report*, 16(1), 255-262.

Ross, E. (2008). Traditional healing in South Africa: Ethical implications for social work. *Social Work in Health Care*, 46(2), 15-33.

Ross, E. (2010). Inaugural lecture: African spirituality, ethics and traditional healing – implications for indigenous South African social work education and practice. *South African Journal of Bioethics and Law*, 3(1), 44-51.

Sadala, M. L. A., Adorno, R., & deC, F. (2001). Phenomenology as a method to investigate the experiences lived: A perspective from Husserl and Merleau-Ponty's thought. *Journal of Advanced Nursing*, 37(3), 282-293.

Saravanan, B., Jacob, K. S., Johnson, S., Prince, M., Bhugra, D., & David, A. S. (2007). Belief models in first episode schizophrenia in South India. *Social Psychiatry and Psychiatric Epidemiology*, 42, 446–451.

Saxena, S., Thornicroft, G., Knapp, M., & Whiteford, H. (2007). Resources for mental health: scarcity, inequity, and inefficiency. *Lancet*, 370, 878-889.

Schachter, S. C. (2014). *Overview of the management of epilepsy in adults*. Retrieved from http://uptodate.com/home

Shetty, P. (2010). *Integrating modern and traditional medicine: Facts and Figures*. Retrieved from www.scidev.net

Shizha, E., & Charema, J. (2011).Health and wellness in Southern Africa: Incorporating indigenous and western healing practices. *International Journal of Psychology and Counselling*, 3(9), 167–175.

Shoko, T. (2007). Karanga Traditional Medicine and Healing. *In African Journal of Traditional, Complementary and Alternative medicines,* 4(4), 501-509.

Shoko, T. (2011). Shona Traditional Religion and Medical Practices: Methodological Approaches to Religious Phenomena. *Africa Development*, XXXVI (2), 277–292.

Sijuwola, O. A. (1995), Culture, religion, and mental illness in Nigeria. In: *Handbook of Culture and Mental Illness: An International Perspective*. In Al-Issa, (Ed, pp. 65-72). Connecticut: International Universities Press.

Sliep, Y. (2009). *Intervention. Healing communities by strengthening social capital: A Narrative*. theatre approach. Diemen: The War Trauma Foundation.

Siriba, R. M. (2014). *The experience of people living with epilepsy in Nhelele, Limpopo Province*. Sovenga. University of Limpopo. (Unpublished masters' research).

Sodi, T., & Bojuwoye, O. (2011). Cultural embeddedness of health, illness and healing: Prospects for integrating indigenous and western healing practices. *Journal of Psychology in Africa*, 21(3), 349–356.

Sorketti, E. A., Zainal, N. Z., & Habil, M. H. (2011). The characteristics of people with mental illness who are under treatment in traditional healer centres in Sudan. *International Journal of Social Psychiatry*, 58(2), 204-216.

Sorsdahl, K. R., Fisher, A. J., Wilson, Z., & Stein, D. J. (2010). Explanatory models of mental disorders and treatment practices among traditional healers in Mpumalanga, South Africa. *African Journal of Psychiatry*, 13, 284–290.

Sorsdahl, K., Stein, D., Grimsrud, A., Seedat, S., Flisher, A.J., Williams, D., & Myer, L. (2009). Traditional healers in the treatment of common mental disorders in South Africa. *The Journal of Nervous and Mental Disease*, 6, 434-441.

Sow, I., translated by J. Diamanti. (1980). *Anthropological structures of madness in Black Africa.* New York: International Universities Press, Inc.

Spilka, B., & Mclntosh, D. N. (1995) ed. *The psychology of religion: Theoretical approaches*. Boulder, CO: Westview.

Ssali, A., Butler, L., Kabatesi, D., King, R., Namugenyi, A., Kamya, M. et al. (2005) Traditional healers for HIV/ AIDS prevention and family planning, Kiboga District, Uganda: evaluation of a program to improve practices. *AIDS Behaviour,* 9, 485–493.

Staff Reporter (11/12/2009). *MPs attack WHO claim 40% Zimbabweans mad*. New Zimbabwe.

Starkowitz, M. (2013). *African traditional healers' understanding of depression as a mental illness: implications for social work practice.* University of Pretoria (Unpublished masters' research)

Struebert Speziale, H. J. & Carpenter, D. R. (2003). *Humanistic Imperative 3rd. Qualitative research in nursing: Advancing the humanistic imperative*. New York. Lippincott Williams & Wilkins.

Strydom, H. (2005). Ethical aspects of research in the human sciences and human service professions. In De Vos, A. S., Strydom, H., Fouche, C. B., & Delport, S. S. L. *Research at Grassroots*. Pretoria. Van Schaik Publishers.

Summerton, J. V. (2006). 'Western health practitioners' view about African traditional health practitioners' treatment and care of people living with HIV/AIDS'. *Curationis*, 29(3), 15–29.

Tangwa, G. B. (2007). How not to compare Western Scientific Medicine with African Traditional Medicine. *Developing World Bioethics*, 7(1), 41-44.

The National Health Strategy for Zimbabwe: 2009-2013. (2013). *Specific diseases affecting Zimbabwean. Retrieved from* www.unfpa.org/sowmy/resources/docs

Thornton, R. (2002) *'Traditional healers and the bio-medical health system in South Africa: summary report – December 2002 (consultancy report)'*. Medical Care Development International (MCDI) for The Margaret Sanger Institute.

Tillman, L. C. (2002). Culturally sensitive research approaches: An African-American approach. *Educational Researcher*, 31, 3-12.

Tilloston, M. T. (2013). Africana Studies: An Anchor in a Liberal Arts Education. *The `Journal of Pan African Studies*, 8(3), 61-70.

Tsala -Tsala, J.P. (1997). Beliefs and disease In Cameroon. In S,N . Madu, P.K Baguma and Pritz, A. (Eds.). *Psychotherapy In Africa: First Investigation* (pp. 44). Vienna. World Council for Psychotherapy.

van Binsbergen, W. (1991). "Becoming a Sangoma: Religious Anthropological Fieldwork in Francistown, Botswana." *Journal of Religion in Africa*, 21(4), 309-344.

Van Niekerk, M. (2014). Perceptions of the Traditional Health Practitioner's role in the management of mental health care users and occupation: a pilot study. *South African Journal of Occupational Therapy*, 4(1). Retrieved from http://www.scielo.org.za/pdf/sajot/v44n1/05.pdf

Viachos, I. O., Stavroula, B., & Hartocolis, P. (1997). "Magico-religious beliefs and psychosis." *Psychopathology*, 30, 93-99.

Vinorkor, M.A. (2004). *Move to protect mental patients*. Daily Graphic.

Wade, C., & Tavris, C. (2006). *Psychology.* 8th. Upper Saddle River; NJ: Pearson Education.

Walley J., Lawn, J. E., Tinker, A., de Francisco, A., Chopra, M., Rudan, I., et al. (2008). Primary health care: making Alma-Ata a reality. *Lancet*, 372(9642), 1001–1007.

Wakundah, J. M. (2012). *Why Protect Traditional Knowledge, African Technology Policy Studies Network*, Nairobi.

Winter, G. (2000). A comparative discussion of the notion of validity in qualitative and quantitative research. *The Qualitative report*, 4, 3-4.

World Health Organization (WHO). (2002). *Towards a Common Language for Functioning, Disability and Health (ICF).* Retrieved from http://www.who.int/icf/beginners/bg/pdf

World Health Organization. (2004). World Mental Health Survey Consortium. Prevalence, severity, and unmet need for treatment of mental disorders in the World Health Organization World Mental Health Surveys. *The Journal of the American Medical Association*, 291, 2581-2590.

World Health Organization. (2005). *Mental health atlas*. Geneva. Retrieved from WHO: [http://www.who.int/whr/2001/en/] webcite

World Health Organization. (2006). *World Mental Health Day 2006: 'Building awareness - Reducing risks:* Suicide and mental illness'. Geneva.

World Health Organization. (2007). *WHO Guidelines for Assessing Quality of Herbal Medicines with Reference to Contaminants and Residues.* Geneva: World Health Organisation.

World Health Organization, WHO (2008). *World Health Organization, Fact Sheet No. 134* (revised December 2008). Geneva, Switzerland.

World Health Organization. (2011). *World Health Organization's Mental health atlas* Retrieved from http://www.who.int/mediacentre/multimedia/podcasts/2011/mental_health_17102011/en/

World Health Organization. (2012). *World Health statistics 2012*. France. World Health Organization. Retrieved from http://www.who.int/healthinfo/statistics/programme/en/index.html.

Wreford, J. (2005). Missing each other: Problems and potential for collaborative efforts between biomedicine and traditional healers in South Africa in the time of AIDS. *Social Dynamics*, 31, 55–89.

Xaba, T. (2002). *The transformation of Indigenous Medical Practice in South Africa. Bodies and Politics: Healing rituals in the Democratic South Africa.* Les Cahiers de l'IFAS no2 Johannesburg: IFAS.

Yen, J., & Wilbraham, L. (2003). Discourses of culture and illness in South African mental health care and indigenous healing, Part I: Western psychiatric power. *Transcultural Psychiatry*, 40(4), 542–561.

Zhang, Y., & Wildemuth, B. M. (2009). Unstructured interviews. In B. M. Wildemuth (Ed.). *Applications of social research methods to questions in information and library science*, Westport. Libraries Unlimited.

Zimbabwe National Association for Mental Health (ZIMNAMH) newsletter (2009). Conditions at Psychiatric Institutions in Zimbabwe: The Case of Ngomahuru Psychiatric Hospital. *Zimbabwe Association of Doctors for Human Rights Newsletter*, 7(2).

Zimbabwe National Statistics Agency (ZimStats). (2012). *Census 2012 national report*. Harare. ZimStats. Retrieved from http://www.zimstat.co.zw/sites/default/files/img/National_Report.pdf

ANNEXURES

Annexure 1a: Interview Guide (English version)

- Kindly share with me your views regarding all the types of mental illness that you know of.
- What causes do you attribute to mental illness?
- Describe to me the different methods that you use to treat mental illness.
- Kindly share with me your thoughts regarding what you consider to be the factors that contribute to your success in treating mental illness.
- Kindly describe what you would consider to be the barriers that traditional healers encounter when they treat mental illness.

Annexure 1b: Interview Guide (Shona version)

- ✓ Mungandiudzewo here mukuziva kwenyu kuti mhando dzezvirwere Zvepfungwa ndedzipi?
- ✓ Chii chamunofunga kuti chinokonzera zvirwere zvepfungwa?
- ✓ Ndedzipi nzira dzamunoshandisa pakurapa zvirwere zvepfungwa?
- ✓ Ndezvipi zvinoita kuti basa renyu rifambe nyore pakurapa zvirwere zvepfungwa?
- ✓ Ndezvipi zvinoita kuti basa renyu risafambe nyore pakura pavanhu vane Zvirwere zvepfungwa?

Annexure 2a: Participant's consent letter and form (English version)

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

Date_____

Dear Participant

Thank you for showing interest in this study that focuses on the views of indigenous healers regarding the causes and treatment of mental illness in Goromonzi, Zimbabwe

Your responses to this interview will remain strictly confidential. Please note that you are participating in this study out of your own will and you have the right to withdraw from participating at any time should you wish to do so.

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

Kind regards

…….	…….
Taruvinga. P	Date
Doctor of Philosophy Student	
…….	……
Prof.Sodi	Date
Supervisor	

Annexure 2b: Participant's consent letter and form (Shona version)

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

Zuva_____

Wadiwa Mupinduri wetsvagiridzo

Ndino kutendai nekuratidza chido mutsvakiridzo inotsvaga kuziva maonero en'anga dzechiZezuru maererano nezvinokonzera nemarapirwo ezvirwere chepfungwa muno muZimbabwe.

Zvese zvamuchataura mukupindura mubvunzo yetsvagiridzo ino zvicha chengetedzwa zvikuru kuti pasawane vamwe vangazvione. Ari kuita tsvagiridzo ino achaona kuti haanyore zvinhu zvingaite kuti ani nani zvake azive kuti zviri muno zvakabva kunaani.
Hapana zita remunhu ari mutsvagiridzo ino richataurwa kunaani nani zvake. Ndino kumbirisa kuti muzive kuti muri kupinda mutsvagiridzo ino nekudakwenyu pasina kumanikidzwa. Maka sununguka kubuda pamunenge madira.

Ndino kumbira kuti mupindure mibvunzo yese ichatevera zvakatendeka. Kuve mupinduri wetsvagiridzo iyi kwenyu kwakakosha zvikuru kwandiri. Ndino kutendai nekuda kwenguva yamandipa nerubatsiro rwamandipa.
Aka vimbika

…… ……

Taruvinga. P Zuva
Muzvinafundo achirikudzidzira

…… ……

Prof.Sodi Zuva
Mudzidzisi

Annexure 3a: Consent form to participate in a research study to be signed by the participant (English version)

Consent form

I_____ hereby agree to participate in a doctorate's research project that focuses on the views of indigenous healers regarding the causes and treatment of mental illness in Zimbabwe.

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

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

Signature: _____

Date: _____

Annexure 3b: Consent form to participate in a research study to be signed by the participant (Shona version)

Chibvumirano

Ini _____ ndabvuma kuve mumwe wevanhu vachange vachipindura mutsvagiridzo yedanho ranamazvikokota vetsvagiridzo inotsvaga kuziva maonero en'anga dzechiZezuru maererano nezvino konzera nemarapirwo ezvirwere chepfungwa muGoromonzi muno muZimbabwe.

Chinangwa chetsvagiridzo ino chatsanangurwa kwandiri zvizere. Ndanzwisisa kuti ndiri kupinda mutsvagiridzo ino nekuda kwangu pasina kumanikidzwa, uye ndakasununguka kubuda pandinenge ndadira. Zvakare sarudzo yekubuda mutsvakiridzo ino haina zvimhingamupini zvingauye nekuda kwayo.

Ndanzwisisa kuti tsvagiridzo ino haizi ine chinangwa chekundibatsira pahupenyu hwangu ndega. Ndanzwisisa kuti zita rangu nezvimwe zvandapa hazvisi kuzoshandiswa kuti vanhu vazive kuti zviri mutsvagiridzo zvapihwa nani. Mhinduro dzangu dzichagara dzisina kusungirirwa pazita rangu.

Signature: _____

Zuva: _____

Annexure 4: Ethical clearance certificate

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

TURFLOOP RESEARCH ETHICS COMMITTEECLEARANCE CERTIFICATE

MEETING:	**08 May 2014**
PROJECT NUMBER:	**TREC/10/2014: PG**
PROJECT:	
Title:	An exploration of Shona Traditional Healers' conceptualization and treatment of mental illness.
Researcher:	Mr P Taruvinga
Supervisor:	Prof T Sodi – University of Limpopo
Co-Supervisor:	N/A
Department:	Psychology
School:	Social Sciences
Degree:	PhD in Psychology

PROF TAB MASHEGO
CHAIRPERSON: TURFLOOP RESEARCH ETHICS COMMITTEE

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

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