An explorative study: mental wellness as perceived by black traditional healers within the South African context

by

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Declaration

I declare that the dissertation, which I hereby submit for the degree MA: Clinical Psychology, at the University of Pretoria, is my own work and has not been submitted by me for a degree at another university.

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Signature Date

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Abstract

From a psychological perspective there seems to be scant knowledge regarding the perceptions and beliefs of black traditional healers in South Africa about mental wellness and, consequently, also about mental illness. The aim of this qualitative study is to encapsulate the beliefs of black traditional healers in terms of four major areas, namely, definitions of mental wellness, definitions of mental illness, causes of mental illness, and approaches to promoting mental wellness.

A convenience sample of black traditional healers was selected to participate in this study. Most of the participants practice in the greater Gauteng region and hold a monthly gathering in the Hammanskraal area where most of the research was conducted. There were no specific requirements in terms of age, gender, or field of specialisation. A total of 37 black traditional healers participated. A questionnaire was used to gather information on the beliefs and perceptions of the participants about mental wellness. The participants completed the questionnaires, after which the data was collected, and then analysed by means of thematic analysis. After the data had been analysed and transcribed it was returned to the participants for them to ascertain whether the interpretations were correct.

The data that was interpreted showed that the black traditional healers participating in this study have very poorly developed definitions of mental wellness, as well as inadequate knowledge about Western mental health workers. The unique definition of mental illness as perceived by black traditional healers gave rise to new insights.

During the research it emerged that there was a pressing need for proper training for black traditional healers in terms of what mental wellness actually is, and the functions of Western mental health workers. Also to the flipside it provides very important insights as to how mental wellness, mental illness and the management or promotion of these are perceived and approached by the black traditional healers participating in this study.

Key words

Black traditional healers
Definitions
Perceptions
Mental illness
Mental health
Mental wellness

Opsomming

Dit blyk dat daar binne die skool van Sielkunde baie karige kennis is oor die oortuigings waarvolgens swart tradisionele genesers in Suid-Afrika geestes welstand en geestes ongesondheid benader. Die doel van hierdie kwalitatiewe studie is om juis hierde oortuigings van die swart tradisionele genesers vas te vang in terme van vier belangrike areas van geestes gesondheid naamlik: (1) Geestes welstand, geestes ongesondheid, (2) definisies van geestes welstand en geestes ongesondheid, (3) die oorsake van geestes ongesondheid asook (4) maniere om geestes welstand te bevorder.

'n Gemaklikheids monster van swart tradisionele genesers is geselekteer wat dien as deelnemers aan die navorsing. Die meeste van die deelnemers praktiseer in die groter Gauteng area en hulle hou 'n maandelikse vergadering in die Hammanskraal area waar die meeste van die navorsing plaasgevind het. Daar was geen spesifikasies in terme van ouderdom, geslag of spesialiseringsveld van die deelnemers nie. 'n Totaal van 37 swart tradisionele genesers het deelgeneem aan die studie. 'n Vraelys was gebruik om die data in te samel rakende die oortuigings van die deelnemers ten opsigte van geestes welstand. Die deelnemers moes elkeen 'n vraelys voltooi, waarna die data ingesamel is en geanaliseer is deur middel van tematiese data analise. Daarna is die geanaliseerde data getranskribeer en aan die deelnemers terug gevoer sodat hulle die korrektheid van die analise en interpretasie kon evalueer.

Die geïterpreteerde data het gedui dat swart tradisionele genesers 'n baie swak ontwikkelde definisie van geestes welstand het, asook swak kennis van westerse geestes gesondheids werkers. Nuwe insigte is saamgestel te opsigte van die unieke definisies van swart tradisionele genesers rakende geestes ongesondheid.

Gedurende die navorsing het 'n dringende nood vorendag gekom vir deeglike opleiding vir swart tradisionele genesers in terme van wat geestes welstand is en wat die funksies van die verskeie westerse geestes gesondheids werkers is. Ook het hierdie navorsing waardevolle insigte verskaf in terme van hoe die swart tradisionele genesers geestes welstand, geestes ongesondheid en die bestuur of bevordering daarvan benader.

Belangrike terme

Swart tradisionele genesers
Geestes gesondheid
Geestes welstand
Geestes ongesondheid
Definisies
Persepsies

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CHAPTER 1

INTRODUCTION

1.1 A short overview

A compelling issue in the realm of mental health in South Africa is the genuine quest to promote cross-cultural understanding within the counselling and therapeutic contexts. This places the discussion squarely in the middle between the currently polarised promoters of mental health, namely, psychology and traditional healing.

The role of a traditional healer in South Africa is far more all-embracing than that of a modern medical doctor. A traditional healer would advise a client about a broad array of issues in daily life – these often include physical, psychological, spiritual, moral and legal issues (Meissner, 2003). Traditional healers share a common worldview with their clients and are therefore able to understand the significance of ancestors and supernatural forces. Modern science or Western medicine has in no way been able to replace traditional medicine, and, according to Meissner, never will.

Traditional medicine is currently faced with enormous challenges. Firstly, the traditional social order is fast disappearing (Meissner, 2003). According to this author It seems there is considerable conflict between that which constitutes traditional norms and values, and the rights of individuals as set out in the Bill of Rights of the 1996 Constitution of the Republic of South Africa. It is common knowledge that modern medical practitioners are providing black traditional

healers with considerable competition – especially in the urban environment. This has resulted in the widespread view that the traditional methods are unscientific, unregulated, and often even harmful – thus making it even more difficult for a traditional healer to defend his practice and administer effective treatment.

However, despite this current attitude towards the traditional social order and the challenges in harmonising Western and traditional healing methods, Meissner (2003) reminds us that traditional medicine will not go away. Black traditional healers existed in South Africa before colonisation by the Dutch in the 17th century, and they have flourished in the face of competition from modern medicine. There are approximately 200 000 traditional healers practising in South Africa, compared with 25 000 doctors of modern medicine; and 80 percent of the black population continue to use the services of traditional healers (Kale, 1995).

Therefore, given this situation, and in the context of a post-apartheid democratic government the opposite debate arises: will psychology as it is practised at present survive? Today in South Africa the main recipients of clinical, psychological expertise and skills are the socially privileged and the white population group. There are certain important factors which account for this situation. Firstly, the concept of the 'talking cure' and the culture of psychology with its strong American and European influence are alien to many African people. It is also argued that the majority of African people prefer to consult traditional healers about their psychological difficulties (Holdstock, 1979; Makau, 2003). Secondly, the field of psychology is largely inaccessible to most African people as most clinicians are white and tend to practise in areas and among clients who are able to afford their services. This often makes them inaccessible to those black people who live in satellite townships. Thirdly, the greater part of psychological practice is privatised and it is generally the financially comfortable, who in South Africa comprise mostly the white population, who are able to afford it. Fourthly, the practice of psychology,

because it has paid little attention to the problems and pathologies of the African working class, has been of little significance to this group of people.

Laungani (1992) reminds us that no culture or society has found all the solutions to the problem of mental illness. It is only when cultures meet – on equal terms and as equal partners – and express a genuine willingness to learn from each other, that one might find tentative answers that could apply to us all. For the West to assume that there is little or nothing that it might profitably learn from the African cultures, many of which have sustained and perpetuated themselves over aeons of time, is precisely the kind of attitude that is inimical to genuine cross-cultural understanding. Bodibe (1993) is of the opinion that the task of scholars in the therapeutic field should not therefore be that of critics of traditional healing, but rather that of students of this alternative healing system.

The importance of this research becomes very evident if we place mental health in its correct place within the multicultural context of South Africa. The main purpose of this qualitative research is to explore and present the current 'mental wellness theory' of traditional healing, particularly in view of its neglect and subjugation by Western practitioners who have, by this neglect and subjugation, demoted traditional healing to the realm of the mystical and the metaphysical. From a Western point of view traditional healing appears to be lacking when compared to any one of the well-documented therapies of the East (yoga) or the West (psychotherapy). However, traditional healing is deeply imbedded in the worldview of a number of indigenous peoples worldwide, and requires recalibration and celebration – not condemnation.

Zane Wilson, founder of the South African Depression and Anxiety Group (SADAG), maintains that there have been great strides in mental health awareness and education through training workshops with traditional healers. She states that not only are traditional healers often the first option people exercise in the (rural) areas, but they are also superb counsellors – listening carefully and without judgment to the patients' worries and problems. She goes

further by saying that the role of traditional healers is comparable to that of psychologists in Western health care.

SADAG began working in the remote rural areas of South Africa in 2000 by educating home-based care workers, traditional healers, schools, and church and youth groups about mental health and psychosocial care.

1.2 Motivation for the study

Traditional healing is a complex issue. The primary reason for this complexity is the way in which ideological orientations have continued to colour and inform assumptions made by researchers and clinicians. Despite empirical evidence and growing clinical experience these assumptions have proved noncompliant to adaptations. For a long time the revival of interest in traditional healing and its approach to 'wellness' were seen as an attempt by people living according to an Afrocentric worldview to refuse treatment offered by the Western model and to cling childishly to old ways, even if it meant jeopardising their health (Freeman & Motsei, 1992).

This served as a strong motivation to explore, analyse and present, from a psychological perspective, the current beliefs as expounded by the black traditional healers treating mental illness and promoting mental 'wellness', in order to bring about a psychotherapeutic intervention compatible with the black South African patients being treated by it.

There needs to be clarification as to why this specific research was carried out from the perspective of clinical psychology. Various changes have taken place within the profession in recent years – prior to 1994 77 percent of psychologists who completed their internships were white compared to only 23 percent black. In the period between 1994 and 2000 there was a change in these percentages – 65 percent of the interns finishing were white and only 34 percent were black (Pillay & Kramers, 2003). This would imply that most of the clinical

psychologists registered with the Health Professions Council of South Africa (HPCSA) were not proficient in the black African languages used by the majority of the country's people (Makau, 2003). Would it be too much of a generalisation to say that there is a high probability that 65 percent of psychologists also then had a very limited understanding not only of black African languages, but also of black African culture (especially black African healing culture)?

The focus of clinical psychology is to treat mental illness – often pathological illness – by determining where the origin of such illness lies (whether by psychodynamic exploration, interactional analysis etc.) and to attempt to assist the client (according to whichever psychological paradigm is preferred by the psychologist) to experience relief (whether by gaining insight, strategic intervention etc) (Nevid, Rathus & Greene, 1997). Every person is in some way influenced by his genetic make-up, upbringing, circumstances, culture and social context – therefore the important role that any one of these elements may play in mental wellness should not be ignored. A proper understanding of the healing paradigm and mental wellness within African culture is thus essential in treating the African client.

The aim of this research will be discussed below, but, as an introductory statement, it needs to be stated that the aim of this research was to explore and gain an understanding of the concept of mental wellness within the sphere of traditional healing. Once this exploration has been completed and the results fed back to the participants to check their validity, the research will be written up in detail and, by making use of reflexivity, the researcher will attempt to make some sense of the data as it relates back to her own psychological frame of reference with regard to mental wellness.

1.3 Aims and objectives of the study

There are compelling signs all around us that the search for solutions to mental health problems involves us all. We neglect this task at our peril. The delegates

at the Southern African Regional Conference on Mental Health Policy (October, 1995) pointed out that is important to bear in mind that the traditional African worldview and spirituality is highly conducive to mental health as regards its understanding of ubuntu, the high value it places on family, and its deep love and respect for children and the elderly. They affirmed that the authentic practice of traditional African forms of healing is vital to mental health in Africa, and that much may be learned from its holistic approach to healing. A better understanding of these elements would enhance therapy/counselling skills and this, in turn, would facilitate the treatment of the African client.

This study, therefore, has the following specific objectives:

(1) Exploration of the beliefs and opinions held by black traditional healers regarding mental illness and mental wellness. Also an exploration of their approach to the promotion of mental wellness.

(2) Presentation of the subjective beliefs and approaches as currently expounded by black traditional healers in South Africa.

(3) Translation of these subjective beliefs and approaches as experienced against the psychological background of the researcher.

Chapter 2 will contain a review of the definitions and explanations of the core beliefs and 'wellness theory' of traditional healing as found in current literature. The researcher made an effort to include as much recent literature as possible. This chapter will also explain key terms related to this research, for example, Afrocentrism, multiculturalism, broad definitions of the Afrocentric traditional healing paradigm, as well as other key terms. Chapter 3 discusses the methodology utilised during this study, and includes the research method, the recruitment of participants, the collection of data, data analysis and so forth. This chapter also discusses ethical issues that could be of importance in this

study. In chapter 4 the findings of the study are presented and discussed in detail, while chapter 5 provides a brief summary of and conclusion to the study.

CHAPTER 2

LITERATURE REVIEW

2.1 Introduction

This chapter will serve as a literature review and will attempt to discuss all literature that is relevant to this specific research topic. Several of these literature sources are rather dated, but provide such basic and important principles that they could not be excluded. Another reason for utilising this literature is the scarcity of contemporary literature on the research topic.

Effective treatment is a pivotal consideration in this research endeavour. Since the early 90s psychological treatment has been gaining in popularity and recognition throughout the entire world (Freeman & Motsei, 1992) as an alternative source of mental health and it is therefore crucial that we reinvestigate our methods, paradigms and ethics. There needs to be an increasing number of trained professionals to meet the growing need for psychological services.

In South Africa increasingly greater numbers of black people are qualifying as psychologists, and there is also a growing number of black people seeking and receiving psychological services. There is a high probability that a person in South Africa utilising psychological services will be seen by a psychologist of a different race to him or herself (Spangenberg, 2003). The obvious challenge therefore is to eliminate possible areas of prejudice (especially prejudice arising from an inadequate knowledge and understanding of the effect of the traditional or cultural context on an individual's psyche), as these areas of prejudice would impact directly on important Rogerian principals such as congruence (realness), empathy (within Rogerian therapy this involves a willingness and ability to enter

the private perceptual world of the client without fear and to become thoroughly conversant with it) and unconditional positive regard (this is concerned with the attitude embodied and conveyed by the therapist in accepting and valuing the client) (Rogers, 1951; Hergenhahn & Olson, 1999).

In South Africa there is a plethora of different cultures, belief systems and traditions. All these different cultures make use of a uniquely constituted 'treatment plan' for illness and problems, for example, Holdstock (1979) describes *isidliso* as a condition localised in the gastrointestinal tract – it is described as something which moves about inside the body. Usually this sensation of movement is regarded as a manifestation of some kind of alien object, most frequently a snake. The presence of this entity causes abdominal pains, feelings of weakness, loneliness, weight loss, sleep disturbance, reduced libido and lowered self-esteem. The sickness is generally believed to be caused by the ingestion of a 'poison', administered by another person with malicious intent. It is only if the therapist/counsellor has some cultural understanding of the aetiology of the *isidliso* that he will be able to make sense of this affliction. He will be in a position to understand the origin of the symptoms and will know what traditional treatment (which in this case would be the administration of emetics prepared by a traditional healer) to apply. The client may be relieved of the disturbing symptoms by utilising the traditional treatment, and then – knowing that the source of the affliction is believed to come from 'malicious' intent – the psychologist will be able to enquire into the patient's social situation, relationships and so on in order to prevent future symptomatology. An immediate referring of the patient for x-rays, laparoscopies or psychiatric intervention is contraindicated (Holdstock, 1979).

2.1.1 Global literature overview

There is a communal ideology and unique worldview between and among the indigenous people of the world. This common thread is inherent in most indigenous cultures despite the severity and sustained duration of the impact of

colonialism or the variance in spiritual practices (Solomon & Wane, 2005). In the worldview of societal and cosmological relationships of indigenous people there is a deep understanding of the concepts of respect for self, for other people and for all of nature, especially land and water. The above authors state that Essential elements of this philosophy are sustainability and balanced harmonious living grounded in a spiritual relationship to the land. People are taught, shown and instructed in their responsibility to learn to (re)connect with the land. This understanding enables them to support each other with sacred medicine, ceremonies and using their indigenous methods of traditional counselling.

This way of knowing, understanding and being in the world originates in the simplicity and complexity of our psycho-spiritual-socio-behaviourist-ecological cosmological worldview (Solomon, 1994) – a worldview commonly known in North America as the 'Medicine Wheel philosophy' (Gunn Allen, 1986; Solomon, 1990). Indigenous peoples the world over follow the rhythm of the cosmos with distinct relationships to the sun, moon, stars, animals, plants, sound, wind, water, electrical and vibrational energy, thunder, lightning, rain, all creatures of the land and water, the air, and the rhythm of the land itself (Solomon & Wane, 2005). Relationships with the spirit world have been of immense value to tribal people in maintaining relationships with their ancestors (Gunn Allen, 1996).

Forefathers introduce the people to the spiritual legacy left to them by their ancestors. The ancestral teachings provide spiritual guidance embodied in the Creator, the giver of life, harmony, balance, cosmic order, peace and healing. Spiritual guidance is also embodied in the earth, spirit and culture giver who represents truth, balance, harmony, law and cosmic order (Wane, 2002).

The ancestors taught that if any actions result in disequilibrium then methods have to be found to heal and purify the environment, relationships, and the self (Wane, 2002). This understanding and the teachings that embody the wisdom were and are of such value that the indigenous peoples scripted the knowledge

within their hearts to be shared with each other and with future generations. In reality this knowledge is embodied because it is committed to memory. “Memory is recorded literally in the viscera, in the flesh” (Jousse, 2000). “Knowledge” for indigenous peoples means *know*-ing the legends and stories. Consequently, one must have a complete knowledge of the legends, to the ends of the stories, or else the knowledge is incomplete. Legends refer to what is known as sacred teachings and the mythological foundations of our cultures (Solomon & Wane, 2005). Relationships with the cosmos are maintained through stories. It is thus vital to know the stories of the land in order to bring about healing the indigenous way (Solomon, 1990).

It is the responsibility of the people to know, understand and respect the healing power of the performed knowledges (Chamberlain, 2003) used by the traditional teachers, elders, ceremonialists, and traditional healers. Performed knowledges, therefore, relate to the indigenous ways of healing which are living texts (Solomon & Wane, 2005). These performed knowledges and texts in orality exist in three-dimensionality compared to the two-dimensionality of written knowledge and texts in literacy. The songs, dances, ceremonies, sacred medicines and traditional languages serve as the vehicle and tool of the healer (Solomon & Wane, 2005). Consequently it is with certainty and caution that the elders and spiritual teachers remind the people not to write down or record the ceremonies, as to do so would “take the life out of them” (Solomon & Wane, 2005). This serves as confirmation that recorded data is unacceptable.

Solomon and Wane (2005) write about an African woman who is a traditional healer. She explained in her interview that her ability to heal is a gift passed down to her from her grandmother. She is still able to recall the many times she witnessed her grandmother healing people through touch. She explained that indigenous healing takes different forms – depending on the situation. She stated that certain healers might prescribe a spiritual bath which is a formal acknowledgement that something needs to be done about your physical, mental or emotional wellbeing. She explained, “beyond the submission in the water and

the candles, there has begun a submission for help for oneself. The spiritual bath is not just a beginning for help, but a solution of help". She continued by explaining that "the type of bath taken depends on the healing needed. Whether it is bath salts, floral herbs, gemstones, spices, nature items such as rocks, pebbles, sand or leaves etc. all depending on the healing needed". She concluded the interview by stating: "I cannot give you a step-by-step description of what needs to be done, because you may apply some of these sacred practices without the respect and integrity passed down by our ancestors" (Solomon & Wane, 2005).

2.1.2 South African literature overview

In recent years there has been a marked increase – in both theory and research – in the contrast between individualist and collectivist cultural orientations (Kim, 1994). It is argued that collectivist societies stress a joint 'we' consciousness, emotional dependence, collective identity and group solidarity, together with a sharing and codes of duty or common obligations. By contrast, individualist societies emphasise personal autonomy, and particular personal friendships – an 'I' rather than a 'we' sense of self-consciousness. In terms of fundamental assumptions, individualist cultures are rooted in the primacy of individual reason and rationality, whereas the profound assumptions of collectivist orientations are those of 'relatedness' – an emphasis on collective welfare.

Although it may be something of an oversimplification, in the rapidly changing cultures that exist in South Africa (e.g. variances among urban or rural groups, age cohorts, class or gender) may be evidence of varying tendencies towards individualism or collectivism, nevertheless, are seen in stark contrast. Modernist and traditional African value systems may differ along broad lines – see the following table

COMPARISON OF VALUE ORIENTATIONS	
CONTEMPORARY WESTERN CULTURES	**TRADITIONAL AFRICAN VALUES**
Subjugation of nature	Harmony with nature
Future, progress and change	Present, following the old ways
Competition (Each person maximising own welfare will maximise general welfare) Private property, acquisition of wealth	Cooperation, conscious submission of self to welfare of the group as a whole Sharing freely, work only for present needs
Fame and recognition	Anonymity, humility
Reliance on experts	Reliance on extended family
Verbal expression	Keeping to oneself
Analytic	Holistic

Source: Sue (1981, p. 225–227)

Traditional healers

"Traditional healers are a very caring people, and extraordinarily skilled in psychotherapy and counselling. Some of them do a damn good job. Of course there are certain horrible ones who poison their patients at every turn" said Prof. Ralph Kirsch of the Department of Medicine at the University of Cape Town Medical School (Kale, 1995).

Black traditional healers existed in South Africa before the country was colonised by the Dutch in the 17th century. They have flourished in the face of competition from modern medicine. About 200 000 traditional healers practise in South Africa, compared to 25 000 doctors of modern medicine. Eighty percent of the black population in South Africa uses the services of traditional healers (Kale, 1995).

2.2 What is traditional healing in South Africa?

2.2.1 Definitions and concepts related to traditional healing in South Africa

The following subsections will focus on important definitions and concepts pertaining to traditional healing in South Africa.

2.2.1.1 What is traditional medicine?

The World Health Organisation (WHO) (2002) states that it is difficult to assign one definition to the broad range of characteristics and elements of traditional medicine, but that a working definition is essential. It thus concludes that traditional medicines include diverse health practices, approaches, knowledge and beliefs incorporating plant, animal and/or mineral-based medicines, spiritual therapies, manual techniques and exercises applied singularly or in combination to maintain well-being, as well as to treat, diagnose or prevent illness.

In this paper the terms ’traditional’ and ’Western’ medicines and practitioners are frequently used. With the employment of these terms the WHO draws a distinction between “traditional medicines” and “complementary and alternative medicines” (WHO, 2002). The latter terms relate to practices such as acupuncture, homeopathy and chiropractic systems – thus a broad set of healthcare practices that are either not part of the traditions of a particular country, or are not integrated into its dominant healthcare systems.

For the sake of this paper the term ’traditional medicine’ or ’traditional healing’ will refer to traditional medicine in sub-Saharan Africa. It also needs to be acknowledged that these terms are awkward, politically loaded and rather unhelpful in describing the principles, philosophy and practices they represent. It is a challenge to assign sensitive and precise definitions to these terms, while no synonyms are readily available. One of the definitions given for ’African traditional medicine’ by the WHO Centre for Health Development is “the sum total of all knowledge and practices, whether explicable or not, used in

diagnosis, prevention and elimination of physical, mental, or societal imbalance, and relying exclusively on practical experience and observation handed down from generation to generation, whether verbally or in writing" (WHO, 2002).

Western medicine or biomedicine is often contrasted with the approach taken by traditional medicine practitioners as described above. The former is usually associated with diseases of the physical body only, and is based on the principles of science, technology, knowledge and clinical analysis that have been developed in Northern America and Western Europe. Biomedical literature refers to the use of traditional medicines such as phytotherapy (the science which deals with the use of herbal medicines for the treatment of illness). Traditional medicine and traditional healers form part of a broader field of study by medical anthropologists known as ethnomedicine (Nichter, 1992).

In South Africa most people associate traditional medicine with herbs, remedies (or *muti*) and advice imparted by *sangomas* or *izinyangas*. Mark Nichter (1992) writes that ethnomedicine entails a study of the full range and distribution of health-related experiences, discourse, knowledge and practice among different strata of a population; the situated meaning of the aforementioned for people at a given historical juncture; transformations in popular health culture and medical systems concordant with social change; and the social relations of health-related ideas, behaviours and practices.

2.2.1.2 What is a 'traditional healer' in South Africa?

Traditional healers are generally divided into two categories – those who fulfil the role of diviner-diagnostician (or diviner-mediums) and those who are healers (or herbalists) (Jolles & Jolles, 2000). The diviner provides a diagnosis, usually through spiritual means, while the herbalist chooses and applies relevant remedies. According to these autors colonial powers and structures have played a major role in changing the cultural landscape and practices of traditional healers and their patients, and have disrupted the distinction between

diviners and herbalists.

The Jolles brothers (2000) write that, as early as 1891 in colonial Natal, certain legislation (such as the Witchcraft Suppression Act of 1957 and the Witchcraft Suppression Amendment Act of 1970) explicitly prohibited diviners from practising their trade. The additional encroachment of 'Western' healthcare systems in South Africa on the practice and livelihood of traditional healers has meant that the roles of the diviner and herbalist have become increasingly blurred. Thus, as the African continent undergoes a process of modernisation, traditional healers are undergoing a strange process of mutation (Jolles & Jolles, 2000). In addition, it may be argued that the AIDS epidemic constitutes an important element in the modernising forces that constantly challenge and change the role and practices of traditional healers.

2.2.1.3 What is involved in becoming a traditional healer?

The following literature will serve merely as an overview and is based on the literature of the Xhosa diviner that is available. It is not the aim of this research to provide an in-depth impression of traditional healing as such, and therefore this presentation does not, by any means, claim to be fully applicable to all the various types of traditional healer and the cultural heritage from which they stem. The finer elements will differ across the broad spectrum of Xhosa, Zulu, Tshwana and other heritages. This presentation does, however, attempt to provide certain basic, points central to the nature of traditional healing in South Africa.

(a) The process of becoming a traditional healer in South Africa

Hirst (1990) gives the following overview of the life history of a typical Xhosa diviner (*igqirha lokuvumisa*). Firstly the candidate will experience a vocational call to office that emanates from the ancestors (*iminyanya*), that is, the collectivity of shades or effective spirits constituted by the senior, male, deceased members of the local agnatic group (Hammond-Tooke,

1989; Petrus, 2006). These ancestral spirits communicate the call to the candidate through dreams (*amathongo, amaphupha*) and visions (*imibono*), peopled by deceased relatives, sacred animals (*izilo*) and medicines (*amayeza*). The diviner candidate (*umkhetwa*) will also experience a condition known as *intwaso* – a technical term derived from the verb *ukuthwasa* which refers to the process of gradually becoming or emerging as a diviner. This process involves various symptoms which do not necessarily refer to disease or illness as defined in Western medical science. *Ukuthwasa* has parallels with adolescent initiation rites and denotes the attainment of social maturity, which may be described as a metaphor for a transformation that takes place gradually in the person who undergoes the experience and subsequently becomes a diviner (Hergenhahn & Olson, 1999). This may be regarded as the equivalent of the process of socialisation which Jung described as the "process of individuation" (Hergenhahn & Olson, 1999). The candidate undergoes a period of apprenticeship under a fully initiated and practising diviner, during which time the candidate receives practice in divination (*imvumisa*) and training in herbal treatment (*impatho*). Finally, the candidate will be initiated as a diviner – a gradual process involving a series of ancestor cult rituals (Hirst, 1990).

Hammond-Tooke (1989) states that, before the initiation ritual of the Nguni diviner, which occurs after a year of two of training, there are frequent séances called *intombe*, through which the troubling spirit may be accommodated by means of dancing (*xhentsa*) in a hut until a trance-like state is reached. Thus, during the ancestor-sent *ukuthwasa* period, the novice would have been exposed to a series of rituals directed to the ancestors, which would have included ritual killings (e.g. a cow), the use of "medicines of the home" (*ubulawus*) and séances (Hammond-Tooke, 1989). Between the séances the novice would accompany the tutelary diviner on his travels and be instructed in the healing properties of medicines. The final initiation rituals take place a year of two later (Hammond-Tooke, 1989).

> Besides the initiation ceremonies of diviners, as well as actual divining, there are certain key elements in the ritual process. The ritual space in which the initiation ceremonies are performed is crucial in creating a sacred area in which communion and interaction with the spiritual dimension or divinities may occur (Hirst, 1990). Herein lies the transformative potential by which the space allows for the adoption of other roles/identities, for example the neophyte diviner or boy to man. Traditional song and dance are also key elements in the initiation of the novice and in the professional practice of the diviner. A regular feature of the initiation period is the singing and dancing of novices after ingesting *ubulawu* (Hirst, 1990). Part of the treatment of a novice diviner is the performance of the *thwasa* dance (*xhentsa*) (Hammond-Tooke, 1989).

In many cultures those people who become healers or shamans do not do so by choice. It is as if they are struck by a serious and debilitating illness. Severe physical symptoms and unusual dreams or waking visions indicate that the person is being called to undergo initiation as a shamanic healer (Kalweit, 1988). It is therefore a shamanic, initiatory illness (Louw & Edwards, 1997).

If those who are chosen accept the call and go through the process of training, they emerge as shamanic healers (Xhosa = *amagqira*; Zulu = *isangoma*). However the illness is unlikely to be cured if they do not respond to the call and undergo the training. They may even die. Among the Xhosa and Zulu this illness is known as *intwaso* (having the illness is called *ukuthwasa kwegqira*: to emerge as a healer).

It is believed that the illness is sent by the ancestors who have chosen the candidate to undergo initiation as a healer. The initiation involves training in work with altered states of consciousness. These abilities will help healers to diagnose and treat illnesses, and generally to be of help in their communities. The following four features of this training illustrate the transpersonal aspects of the process and the importance of altered states of consciousness:

- Importance of dreams: Images which indicate contact with the spirit world, for example images of ancestors are regarded as very significant.
- Performance of rituals: As a means of honouring and communicating with the ancestors. Many rituals involve going to the river and leaving offerings to the river people (Buhrmann, 1986). The river people are not literally in the actual, physical river as we know it, but in a river in the non-ordinary world that may be visited in dreams and other altered states. Rituals provide a way of working on the boundary between the two realities.
- Entering altered states of consciousness: Assisted by a group of people who are clapping, chanting and drumming. In this state the healers may hear voices guiding them or giving them advice. These voices are attributed to the river people. The healers may also see images or feel sensations in their bodies which provide them with information about the problem in the patient's body (Louw & Edwards, 1997). The healers may also enter a possession trance and utter a stream of words, often very quickly, as if beyond conscious control. This stream of words often provides information about the problem.
- Extrasensory perception is used to obtain information about what is wrong with the patient and how the patient may be cured. This is facilitated by the altered state of consciousness.

African traditional healers do not attribute all psychotic symptoms to *intwaso*. Some symptoms are attributed to spirit possession illnesses, such as *amafufunyana,* and others to madness (*ukuphambana).* However, like shamans worldwide, they believe that, in cases of *intwaso,* it is possible to create a safe place where the person is able to experience these altered states under guidance. The person will then emerge stronger and healthier and be able to offer wisdom and healing to the community.

2.2.1.4 Ideas about illness

Ideas about sickness and attitudes toward health vary widely in society today. To the African the notion of health refers to a state of complete well-being, based on a way of living, good conduct and abilities in relation to the other members of the family group. This notion of health gives due respect to the dignity of the person and brings about a link between the person and his society, community, and the ancestors. Historically, health in the African tradition presumed a unity of body and spirit (Ngong, 1998)

Sickness is perceived as any health disorder resulting from a complex interaction between heredity and environment, nature and nurture. Sickness is viewed as psychosomatic (Ngong, 1998). In other words sickness is understood to be a complex interaction of physical and physiological, sociological and spiritual factors. Disease is a supernatural phenomenon governed by a hierarchy of vital powers, beginning with the most powerful deity followed by lesser spiritual entities, ancestral spirits, living persons, animals, plants and other objects. These powers are able to interact, and they may reduce or enhance the power of a person. Disharmony in these vital powers may cause illness. Ingredients obtained from animals, plants and other objects are able to restore the diminished power in a sick person and therefore these ingredients are believed to have medicinal properties (Kale, 1995).

The African traditional concept of health and the practice of healing are linked with the practice of traditional religion. Traditional African religion recognises different ways of dealing with sickness and affliction through religious experts or specialists (traditional healers) whose duty it is to discover the causes of disharmony in the community, society and the universe at large. Consequently, religious consideration is given not only to matters pertaining to the restoration of health after sickness, but also to the general preservation of health in the whole community (Ngong, 1998).

Although organic causes of illness, for example that the patient has malaria because he or she has been bitten by a mosquito carrying the malaria parasite, are recognised and accepted, the patient will still wish to know why that particular mosquito stung him or her and not another person. The African approach differs considerably from the Western approach, which considers disease solely to be the result of organic agents or impersonal biological processes, while traditional medicine considers disease as a disequilibrium in the entire body, sometimes even in society as a whole. Treatment of the sick or troubled person entails a process involving several steps, and usually commences with tentative consensus reached by the family members. Sometimes consensus will be reached by a kin diagnostic group led by the elders of the extended family who assemble in the clan together in order to reach a deeper diagnose of the meaning of the patient's illness (Ngong, 1998).

Although *intwaso* is considered to be a culture-bound syndrome, shamanic initiatory illnesses are found all over the world, for example, in Siberia and among Native Americans. These illnesses are not even confined to traditional rural and pre-industrial societies. Although the shamanic tradition in Europe was suppressed centuries ago certain Westerners who develop psychotic illnesses may themselves be undergoing a shamanic initiatory illness. This would best be treated in the way African traditional healers work with people with *intwaso*.

According to Grof and Grof (1989), they have seen instances where modern Americans, Europeans, Australians and Asians have experienced episodes that bore a close resemblance to shamanic crises. They call the process spiritual emergence. Although not writing from an African perspective, this is virtually a direct translation of *intwaso*. The DSM system has been criticised (Louw & Edwards. 1997) because it does not provide any account of this type of process.

2.2.1.5 Efficacy of black traditional healers

Unfortunately there have been very few studies done on the efficacy of the

treatments carried out by traditional healers – the more recent studies focus mainly on their treatment of HIV and are more prone to be a debate on the ethical issues regarding their involvement in this kind of treatment from a medical/scientific point of view, than on their efficacy in promoting overall wellness. The traditional healers are, however, believed to be effective in their treatment of diarrhoea, headaches and other pains, as well as in sedating patients (Kale, 1995). According to Prof. Kirsch (Kale, 1995) their success in the treatment of psychological problems is well known.

2.2.1.6 Black traditional healers in a modern healthcare system

Traditional healers were banned in South Africa for a long time by the Health Act of 1974 (Kale, 1995). Currently there are, however, various organisations attempting to register traditional healers formally – for instance the Southern African Traditional Healers Council, the Association of Traditional Healers of Southern Africa, the Congress of Traditional Healers of South Africa, the African Dingaka Association and the African Skilled Herbalists Association (Freeman and Motsei, 1992). It is still evident that, despite being informally recognised and vigorously researched (especially by sceptic Western scientific medicine), the traditional healers have not yet been allocated their rightful place in the treatment of mental health.

2.2.1.7 Lessons for modern medicine

The practitioners of Southern African traditional medicine follow three principles which could be of benefit to Western medicine. Firstly, patients must be completely convinced that they and their symptoms are being taken seriously, and they must be given enough time to express their fears. Secondly, the healer studies the patient holistically and deserves credit for not splitting the body and mind into two entirely separate entities. Thirdly, the healer never considers the patient as an individual in isolation, but rather as an integral component of a family and a community. Members of the patient's family participate in the

treatment process (Kale, 1995).

According to Kale (1995), Dr. Brian Robertson from the Department of Psychiatry at Grootte Schuur hospital in Cape Town stated 10 years ago that:

> A lot depends, however, on how mental health is defined, what indicators of mental health are used, and the effects of protective factors. If mental health is defined broadly as symptoms rather than categorical illnesses, there are clear indications that the mental health of South Africa has been seriously damaged: I am referring to indicators such as the high levels of substance abuse, crime and violence (Kale, 1995).

This implies that there have been grave errors in South Africa's approach to the promotion of mental health in the past.

In South Africa there is an organisation known as "Ububele" – an African psychotherapy resource centre. *Ububele* is an isiXhosa word which encapsulates the concepts of kindness, compassion and empathy. It is derived from the word *amabele* meaning 'breasts' and it is the nurturing quality of the breast and the primary important relationship between mother and child that is encapsulated in the term *ububele*. It seems, therefore, that there is hope, and space and resources for a proper definition of mental health – as it manifests in black African culture.

2.3 Theoretical framework

For the purpose of this research the researcher chose systems theory as the foundation on which to build the research methods and research findings. A condensed discussion of the literature available on systems theory as it applies to this specific research endeavour will follow.

2.3.1 Characteristics of systems theory

A system is a simple way in which to form a unit (Jansen van Vuuren, 2002). A system has a multidimensional element because of its interrelated nature and it is therefore possible to apply it to both micro and macro scales (Jansen van Vuuren, 2002). The social world may be seen as the backdrop against which the interaction of the various parts of the system may be analysed in respect of their unique and dynamic relationship with one another. A strong argument of systems theory is that it is not possible to deal with the inherent relationship of the parts outside of the context of the whole (Ritzer,2000) his argument is especially significant in terms of this specific research as the perceptions of the black traditional healers as subjectively reported may not be interpreted – in the same manner – from outside of the encompassing notion of their 'Africaness' or rather, from outside the foundation of their cultural belief system. South African black traditional healing is a subsystem within a greater belief system. This research interpretation does not have sufficient scope to include an in-depth examination of the greater system of which traditional healing forms a part, but throughout the research there is, a strong awareness of this greater system. Also, any one of the subjective research findings (as presented in the section on research findings) would lose their impact if taken out of the context of traditional healing.

In order for this research to be effective and sound, the researcher had to consider and be sensitive to all (however limited due to the researcher's Western background) aspects of the participants' social, cultural and spiritual awareness as they relate to their perceptions. In systems theory all the facets of the sociocultural system must be understood and considered in terms of process (networks of information and communication) (Jansen van Vuuren, 2002). This brings us to a core characteristic of the systems theory, namely, 'integration'. This term implies the incorporation of large structures, symbolic systems, actions and interactions as well as consciousness. Systems theory regards the social world in dynamic terms – an awareness of sociocultural

dynamics in general (Ritzer, 1992). Although there is not space enough to present all the sociocultural dynamics in this research enterprise, it is, nevertheless, the hope of the researcher that an awareness of all (or hopefully of most) of these dynamics will be communicated in the manner in which the research was approached, conducted, written up and presented.

2.3.2 Principles guiding systems theory

2.3.2.1 Wholeness

The characteristics of a system's properties differ from those of their individual parts as a result of the interdependence that exists between the various parts within the system. As a result of the mutual effects that each part has on the other parts of the system, a system is more than merely the sum of its parts (Lubbe & Puth, 1994, p. 43). During the research endeavour this principle became very obvious, for example, a participant would comment on his beliefs about the causes of mental illness, and, during the analysis of his response and the areas of his focus, it would become clear that this specific healer, who forms part of the system of traditional healing, is also inevitably linked to numerous other parts of this system – firstly, he belongs to a specific subtype of traditional healers; he also belongs to a certain gender group within traditional healing; and he is a member of a certain age group (with the resultant differentiation in terms of approach). Each link between the various parts or elements of this system creates a dimensionality that is bigger (probably immeasurable) than merely listing the different parts as such.

2.3.2.2 Hierarchy

Every system is part of a hierarchy – this means that each system is part of a greater system and, at the same time, consists of various subsystems (Jansen van Vuuren, 2002). The lower the level of the system the more simplistic and mechanistic its functioning becomes, and vice versa (Lubbe & Puth, 1994). Traditional healing is part of a greater system that may be called African traditionalism, and this, in turn, may also be seen as part of an even bigger

system which refers to international, alternative, healing techniques and approaches. Simultaneously, traditional healing also consists of a multitude of smaller systems – these would include the different types of traditional healing method, the various correlating approaches, its role in physical, mental, social and spiritual awareness, and, definitely, also its role in the specific community within which it is practised – the list of possible subsystems goes on.

2.3.2.3 Self-regulation

The goal of the system of traditional healing in South Africa may be broadly described as enhancing the lives of individuals by providing a service that aims at curing that which is unwanted and promoting that which is seen as desirable – some form of guidance would clearly be necessary in order to be able to achieve these goals. According to Jansen van Vuuren each system poses such a regulative principle that it serves as a guide in attaining the goals of the systems (Jansen van Vuuren, 2002). The lower the hierarchical level of the system the more simplistic the goals may be, while the goals become extremely complex the higher the hierarchical level (Lubbe & Puth, 1994).

2.3.2.4 Openness

There is a definite distinction between open and closed systems. A closed system is detached from its environment and has very rigid boundaries that inhibit adaptation and result in “maximum disorder” (Lubbe & Puth, 1994). An open system, on the other hand, has permeable boundaries that allow the exchange of information and material with its environment – giving it the potential to evolve into greater complexity. The traditional healing system in South Africa probably operates as an open system in most instances, as it constantly has to include and share aspects of the social environment in which it operates in order to fulfil its goal. However, there are systems within traditional healing that function as closed systems – for example the training system of traditional healers is kept very secret, and is very resistant to change or intrusion from outside.

2.3.2.5 Adaptability

A system is not static – it has a dynamic nature. The emphasis is on the process rather than on fixed structures. An open system is able to change and adapt to its environment. It makes sense then that a system will respond to changes in its environment and, at the same time, also actively engage with the environment (Lubbe & Puth, 1994). There is much debate about the adaptability of the traditional healing system in South Africa – some argue that it is static and, in fact, rather stubborn, and not in touch with the events of the 21st century, while others praise traditional healing for its durability, and ability to colour and match its environment as the need arises, while still attaining its goal. This would very much depend on the life perspective of the person offering his opinion – a Western orientated mind would most likely perceive the traditional healing system to be rigid and static, while an African (or even Eastern) mind would see it as dynamic and encompassing in terms of ability and role.

In general systems theory the researcher describes those processes taking place in the outside environment. The researcher's function is to remain an outsider, and to describe his observations in an 'objective' manner (Miller & Miller, 1992). However, this is seldom, if ever, possible. In this research endeavour the researcher did remain an outsider, commenting on the processes and aspects of the research, but despite this, the research will inevitably be coloured by the researcher's own subjective experience.

According to the eco-systemic approach there exist multiple realities – this means that every single person would provide a unique and subjective account of the way in which he or she experiences his or her world. The implication therefore is that there may be multiple variations in the way in which the same situation may be experienced (Visser & Moleko, 2005). With the eco-systemic approach the role of the researcher takes on a different dimension, namely, that he or she cannot and does not have to remain objective, but rather becomes part of the system. The researcher will thus form his or her own conceptions

based on their particular frame of reference. This approach will be pivotal in terms of this research. This research will be exploring ideas and beliefs which are foreign to psychology, with the aim of attempting to make sense of them from a psychological point of view.

CHAPTER 3

RESEARCH METHODOLOGY

3.1 Introduction

This chapter aims to highlight certain important considerations regarding the methodology adopted in this research. Firstly, the chapter will examine the qualitative approach to research as used in this research endeavour, as well as the rationale behind it. Next, it will focus on the research topic, and on the aims and objectives of the study. The research questions will be discussed during the course of this chapter in order to highlight them as the pivotal points of the research venture. The research setting and the participants will also be discussed. Some time will also be spent debating the ethical issues related to this specific research. Lastly, the actual processes regarding the collection and analysis of the data will be discussed, and the chapter will then conclude with a condensed presentation of the reliability and validity of the research.

3.2 Qualitative research

3.2.1 Overview of qualitative research

In the social sciences, qualitative research is a broad term describing research that focuses on the way in which individuals and groups view and understand the world, and construct meaning out of their experiences. Qualitative research focuses on the understanding of research phenomena *in situ*; that is, within their naturally occurring context(s). One aim of the qualitative researcher is to elicit the meaning(s) the phenomena have for the actors or participants.

Generally, qualitative research studies rely on three basic data gathering techniques: participant observation, interview and social artefact (usually, documents) content analysis (Wolcott, 1995; 1999). Each of these techniques represents a continuum of structure ranging from less to more (DeWalt & DeWalt, 2002). Various studies or particular techniques may rely more heavily on one data gathering technique than another.

Epistemologically qualitative methods insist that we should not invent the viewpoint of the actor, and should only attribute to him or her ideas about the world he or she actually does hold, in order that we may truly understand his motives, reasons and actions (Becker, 1996).

3.2.2 Applications

Though it had its genesis in the fields of journalism, anthropology and sociology, qualitative research has burgeoned into and been taken up by many fields. Anthropology contributed to the field of qualitative research with its development of the research method of ethnography — a type of cultural translation (Boas, 1943; Malinowski, 1961).

Qualitative research has gained in popularity, especially as a result of the linguistic or subjective emphasis taking root throughout the world (Giddens, 1990). The social sciences especially, but laypeople as well, are more readily accepting of a subjective (as opposed to an objective or objectivist) ontology. Its practitioners tend to believe that qualitative research is particularly well-suited to gaining an understanding of the subjective qualities of the lived world, although this belief is far from universally accepted.

As a result of the emphasis on in-depth knowledge and elaboration of images and concepts, qualitative methods have been viewed as particularly useful in the areas of social research, such as ’giving voice’ to marginalised groups, formulating new interpretations of the historical and cultural significance of various events, and advancing theory as, in-depth, empirical qualitative studies

may capture important facts missed by more general, quantitative studies. Such investigations usually focus either on a primary case, on the commonalities between separate instances of the same phenomenon identified through analytic induction, or on parallel phenomena identified through theoretical sampling (Ragin, 1994).

3.2.3 Rationale for utilising qualitative research

The choice of a research methodology is one of the greatest problems when conducting scientific research – especially in the field of humanities. The conflict between qualitative and quantitative research will most likely last a long time. There are those scholars who support the qualitative method with all its innovative features, and there are those who proclaim the importance of the structure provided by the quantitative method. A definition of qualitative research that seems to match the aims and objectives set out in this research is the definition of Malterud (2001), who describes qualitative research as the systemic collection, organisation and interpretation of textual material derived from talk or conversation. The qualitative research approach was chosen mostly for its in-depth and thick descriptions of the research phenomenon.

Quantitative research bases its findings on numerical values that may be assigned to a variable and then manipulated by means of various statistical procedures (Morse, 1994). The reason, therefore, for preferring qualitative to quantitative research would lie in the applicability of qualitative research when confronted with variables that would not be of any significance when quantified, or with variables that would lose their value when quantified – these variables could be human experiences, feelings, hopes and so on (Morse, 1994). Qualitative and quantitative research do have certain similarities, but the nature and assumptions of the data to be collected lead to the use of more varying procedures (Malterud, 2001).

There is always a challenge in finding relevant information among the rich and

full data collected by means of qualitative research. Sifting for information and themes, and then adding it together so it reflects the true nature of the data is crucial in attempting to answer the research question. It is critical for any researcher using the qualitative method to realise that good qualitative research does not exaggerate the extent of the material. During analysis the researcher should have a thorough knowledge of the study material so that s/he is at all times acutely aware of the content of the data and its meaning (Malterud, 2001).

The analysis of qualitative data implies three central elements: abstraction and a degree of generalisation, decontextualisation and recontextualisation. Generalisation entails the use of subjective, individuated information to gain knowledge that might be applicable to others. Decontextualisation involves the researcher allowing parts of the subject matter to be extracted and investigated, together with other themes collected across the data span that convey similar themes. Recontextualisation works parallel to decontextualisation in ensuring that the themes and fluctuations continue to match the context from which they were collected (Malterud, 2001).

3.3 Aims of research

This aim of this research is to explore and describe the authentic experiences of black traditional healers in terms of their beliefs about and approach to mental wellness. These specifiers – tending to description of a psychological phenomenon and the way in which it reflects the specific experiences of specific people in a specific time and place – do not need to be quantified and, as such, will be of little use.

3.4 Objectives of this research

The objective of this research is to gather definitions and thick descriptions from the participants in terms of the four areas of focus of this research, namely, the definition of mental wellness, the definition of mental illness, causes of mental

illness, and ways to promote mental wellness as told by the black traditional healers participating in this research. These objectives are listed in chapter 1.

3.5 Research questions

The research question may be formulated in terms of the aims and objectives of this research as stated above and in chapter 1. The research question is based on the four main research themes. These themes were used to formulate four sub-questions pertaining to the aims and objectives of the research – (a) What are the perceptions of black traditional healers regarding mental wellness?; (b) What are the perceptions of black traditional healers regarding mental illness?; (c) What are the perceptions of black traditional healers regarding the causes of mental illness?; and (d) What are the perceptions of black traditional healers regarding the promotion of mental wellness?. The underlying research question would pertain to the traditional healers' overall definition of mental wellness.

3.6 Research settings and participants

The research took place in a community setting. The research population consisted of black traditional healers practising within the greater Pretoria region. The types of black traditional healer included in the participants depended on the willingness of the various practising black traditional healers to participate in the study. According to a practising herbalist who chose to remain anonymous after providing this information, word-of-mouth referrals among Pretoria's inner-city hawkers are quite common – this would be the starting place. Another group of participants was recruited from a rural district on the outskirts of Gauteng. A group of traditional healers hold an annual meeting at Jubilee Hospital in Hammanskraal – these healers practise within the broader region. This group of healers were contacted and they were willing to be included in the research. The participants were therefore drawn from a convenient sample.

After all possible participants (45 in total) had been visited and the purpose and aim of the study explained, 37 participants remained willing to be included in this research.

The participants varied in age from 23 to 69 years old. The participants also varied in gender – the majority of participants were male. However, as this was a qualitative research endeavour the biographical profile of the participants was not paramount to the research findings. All participants were practising traditional healers, with varied fields of specialisation. They were all Tshwana speaking and from the black ethnic grouping. All participants were able to converse in English, but most were unable to read or write English.

3.7 Ethical issues

The next section will focus on the ethical considerations that apply to all qualitative research endeavours. The researcher has tried to comment on all crucial aspects in terms of conducting research that is ethically correct and unobtrusive. In each subsection the ethical issues, as they correspond to this specific research, will be mentioned.

3.7.1 Codes of ethics

(a) Voluntary participation, privacy and informed consent

Social research often invades a person's privacy, and therefore nobody should be subjected to it unless he or she has agreed to it. Participation in research must be voluntary and people have the right to refuse to divulge certain information about themselves. This right to privacy demands that direct consent for participation must be obtained from all participants. Moreover, this consent must be informed, in the sense that the participant must be aware of the positive or negative aspects,

or consequences, of participating in the research. The research may involve stress, discomfort, or even harm to the participants, all of which they may not be prepared to tolerate. On the other hand their 'suffering' may lead to positive and more general social benefits. Thus by explaining the positive and negative aspects co-operation may be assured (Bless & Higson-Smith, 1995).

(b) Anonymity

Many people, for the sake of scientific progress, are prepared to divulge information of a very private nature on condition that their names are not mentioned. Anonymity did not constitute a serious constraint in terms of this specific research as the researcher was more interested in the grouped data. Thus, either the names of participants could be omitted altogether or respondents could be identified by number instead of by name. In the case of this research the participants were each assigned a letter of the alphabet. Since many participants regard anonymity as essential, they must be convinced that this privacy will be respected (Bless & Higson-Smith, 1995).

(c) Confidentiality

In many cases it is not possible to maintain anonymity, especially when data is collected by means of interviews. The interviewer has direct contact with all the participants and is able to recognise each one of them. In this case participants must be assured that the information given will be treated confidentially. This means that they must be assured that the data will be used only for the stated purpose of the research, and that no other person will have access to the data. Once assured of these conditions, a participant will feel free to provide honest and complete information.

3.8 Collection of data

For this research a single interviewer presented a questionnaire to each participant individually. The interviewer was a psychiatric nurse working at a district hospital in a rural community. The questionnaires were to be completed in writing. The characteristics of an interviewer are crucial. Although it is impossible to be totally neutral the interviewer was made very aware of the influence she could have – in whatever way – on the respondents, and she was urged to try and present the responses of the participants as they gave them, and to try to be as objective as possible. It is important to try and match the interviewer and participants on as many levels as possible. The following criteria were important in selecting the interviewer:

1. The ability to speak the home language of the participants
2. The interviewer had to match the ethnic grouping of the participants
3. The researcher preferred to use an interviewer from the same area as the participants

Meeting these criteria was very difficult and time consuming. The interviewer was briefed about the aim and objectives of the research, and possible pitfalls. The interviewer was herself involved in a qualitative research endeavour for the completion of her studies in the human sciences. She was well informed as to the guiding principles, underlying assumptions and research methods linked to qualitative research, as well as the collection of data from such a basis. However, two ’training’ sessions were held with the interviewer to discuss this specific method of research and the focal areas of this research pertaining to the qualitative school of research. The articles and references used by the researcher in the formulation of this chapter were also made available to the interviewer – she was already familiar with most of these.

The researcher accompanied the interviewer to all meetings with the various participants so as to minimise any possible deception of the participants.

Although most of the conversations and discussions were conducted in Tshwana, the researcher maintained a semi-active role – responding to any questions asked and giving information as was deemed necessary.

The questionnaires were compiled in such a manner that the answers would provide information on the perceptions and approaches of the various participants. The questionnaires were to be completed in writing by the participants themselves and, where necessary, the interviewer was asked to write on behalf of the participant. The aim was to collect a reasonable amount of diverse responses from the black traditional healers, as all the various types of black traditional healer (with their complementary belief systems) were included.

Each participant was given basic information about the reason for, the process and aim of the research. Participants were given a letter of consent which was read to them and, where necessary, clarification was given by the researcher. Participants who were willing to take part in the research signed the letters of consent and received a questionnaire. Participants who requested extra information were assisted and most of these conversations were also noted. Participants who needed help completing the questionnaires were assisted. These written, verbatim questionnaires were collected from each participant.

3.9 Data analysis

The data were analysed by means of thematic analysis. The findings were written up and then taken back to the participants for scrutiny and opinions (feedback session). An arrangement was made with the participants to be present at the feedback session where the findings were discussed in order to ascertain whether the researcher's interpretation was a true reflection of what the participants had wished to convey. Their opinions were noted and, where necessary, adjustments were made. The final results were then written up in

chapter 5 of this dissertation, and are followed by a reflective report of the way in which the research process and findings had impacted on the researcher.

3.9.1 Thematic analysis

The data analysis in this research was carried out on the basis of thematic analysis. Thematic analysis focuses on identifiable themes and patterns of living and/or behaving (Aronson, 1994). Ideas that emerge from conversations that take place or from questionnaires are often better understood under the auspices of a thematic analysis.

Thematic analysis is strongly influenced by Charmaz's (Charmaz, 1990) theory of social constructionist/symbolic interactionist perspective (Tuckett, 2005). Social constructionism is concerned with the construction of knowledge and therefore meaning through the social involvement of agents within a social context, and accepts that multiple constructions of meaning are possible based on the different constructions of those engaged in the social interaction (Crotty, 1998).

3.9.1.1 Key phases in analysis of data: organising, reading and theme development

3.9.1.1 a) Data organisation

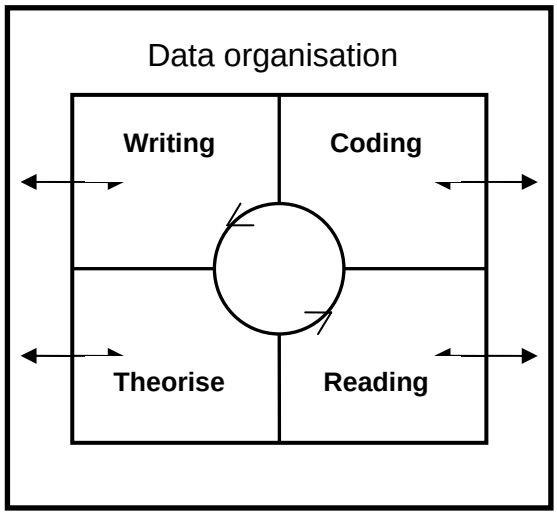
Data organisation is integral to the overall process of data analysis (Van der Heide, 2001). The systematic management of the data is necessary for analytical thoroughness. Logical data organisation becomes the pillars on which data analysis rests. Analysis thus starts at the beginning of the study as the coding, writing, theorising and reading take place simultaneously (Higginbotham, 2001). See figure 3.6.1.1(i) for a diagrammatical presentation of the simultaneous process of data organisation. However in this research all four processes (theorising, writing, reading and coding) did not take place

in sequence, but rather in a simultaneous, complementary manner as the research endeavour proceeded.

3.9.1.1 b) Reading

The first aspect of data analysis is, of course, the literature review as presented in chapter 2 of this dissertation. According to Tuckett (2005) this initial reading is necessary for a practical reason – the identification of a unique research question. The literature review is thus not a separate sequential reading step in the research process – it is ongoing (several important pieces of literature were added to chapter 2 during and after the research process). This allows for creative interaction between the various processes of data collection, literature review and researcher introspection (Tuckett, 2005).

Figure 3.6.1.1(i) Organising, coding, writing, theorising and reading



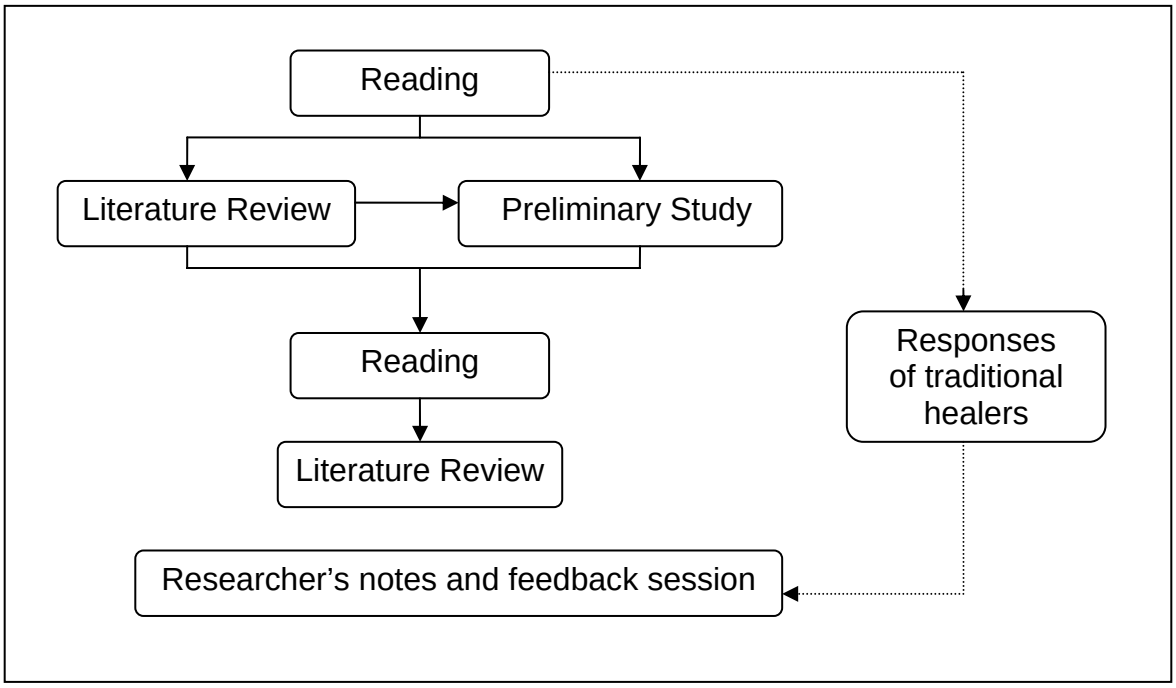
Source: Adapted from Tuckett, 2005, p. 75-87

In this research it was impossible to predict the participants' responses and definitions and thus a thorough review of the available research was imperative – not because it was used to cloud the expectations and judgments of the researcher, but to create an

awareness of current beliefs (and in the case of this research mostly past beliefs as there is very little current literature available). However, the researcher had to be very careful not to let any of the literature sources cloud her openness to the emerging themes (Tuckett, 2005).

Although the literature review was ongoing throughout the research endeavour – and more specifically during the write-up phase (Tuckett, 2005) – it was used to confirm certain research findings, and also gave the researcher the opportunity to confront and add to the existing body of literature (Strauss & Corbin, 1998). The essence of these findings was written up in the research proposal that was presented before the inception of the full study – in this case the research proposal sufficed as the preliminary study (Tuckett, 2005). See figure 3.6.1.1(ii) for a diagrammatical presentation of the way in which the reading phase was implemented in this research.

Figure 3.6.1.1 (ii) Reading: literature review and preliminary study



Source: Adapted from Tuckett, 2005 p. 75–87

3.9.1.1 c) Theme development

The responses of the traditional healers were grouped into four categories based on the four questions posed in the questionnaires. These four categories were (1) Definition of mental wellness; (2) Definition of mental illness; (3) Causes of mental illness; and (4) How to promote mental wellness. The data collected from the responses to each of these four questions was then reduced (Tuckett, 2005) – this implies that all the responses similar in content and reference were grouped together, for example the following responses appeared to question 3: “talking too much inside the heart”; “one who is talking too much, but not by mouth, inside the heart”; “too much talking inside the heart”; “talking deep inside the heart”. These responses were grouped together as a similar response related to the causes of mental illness. When these responses were discussed during the feedback session it became apparent that this refers to heavy and ongoing introspection without being able to verbalise. Thus the theme that developed from this is that heavy and ongoing introspection causes mental illness.

This same process was repeated for each question and themes were confirmed only once the data had been fed back to the participant group and affirmed (Tuckett, 2005).

3.9.1.2 Steps in thematic analysis of this research

The first step is, of course, the collection of the data (Spradley, 1979). Audiotapes are the preferred method of capturing data for the purpose of thematic analysis; however, the participants in this specific research were very apprehensive and uncomfortable with the use of any recording device. Accordingly the researcher decided to make use of questionnaires and notes that were made during and kept after meetings with the participants. Patterns of experiences were listed (Aronson, 1994) from the questionnaires and/or transcribed conversations. These came from direct quotes or paraphrasing

common ideas.

The next step was to identify all the data that related to already classified patterns (Aronson, 1994) – there may be many patterns that emerge from one questionnaire or conversation. The task then is to combine and catalogue related patterns into subthemes. Themes are defined as units derived from patterns such as “conversation topics, vocabulary, recurring activities, meanings, feelings, or folk sayings and proverbs” (Taylor & Bogdan, 1989, p. 131). Themes are identified by “bringing together components or fragments of ideas or experiences, which often are meaningless when viewed alone” (Leininger, 1985, p. 60). Themes that emerge from the participants’ responses are pieced together to form a comprehensive picture of their collective experience (Aronson, 1994).

The final step would be to build a valid argument for choosing the themes. This is done by reading the related literature. By referring back to the literature the interviewer acquires information that allows him or her to draw inferences from the interview or questionnaire. Once the themes have been collected and the literature studied the researcher is ready to formulate theme statements in order to develop a “story line” (Aronson, 1994) or conclusion.

3.10 Reliability and validity within qualitative research

Although validity and reliability are both important in the evaluation of an instrument they are entirely different concepts. An instrument with high reliability would be useless if it had poor validity. Similarly, an instrument with very low reliability should not be used merely because it has very high validity (Bless & Higson-Smith, 1995). While reliability asks the question “How accurate and consistent is this instrument?”; validity asks questions such as “What does this instrument measure?” and “What do the results mean?”. Unless we can be sure that our techniques are actually measuring what they are supposed to be measuring, we cannot be certain what the results mean.

3.10.1 Reliability

Reliability is concerned with the consistency of measures. An instrument which produces different scores every time it is used to measure an unchanging value has low reliability. It cannot be depended upon to produce an accurate measurement. On the other hand, an instrument which always gives the same score when used to measure an unchanging value may be trusted to give an accurate measurement and is said to have high reliability (Bless & Higson-Smith, 1995). In most cases, the reliability of measurement is the degree to which that instrument produces equivalent results for repeated trials. Unfortunately very few instruments ever produce entirely consistent results, as there are many sources of inconsistency. It is worth mentioning that in the social sciences – and qualitative research specifically – there is concern about establishing regularities of perceptions, opinions, behaviours and so on. If a degree of regularity is observed in a phenomenon it is more likely that something meaningful is being measured (Bless & Higson-Smith, 1995). In this qualitative research it was difficult to measure and establish reliability, as the aim of the research was to explore and probe the current status of mental health treatment. In view of the fact that there was so little new literature and research with which to compare this research to, the hope is that this research will, in fact, serve to increase the reliability of future research in this field.

3.10.2 Validity

There are four very important types of validity that need to be taken into account – (a) content validity, (b) criterion-related validity, (c) construct validity and (d) face validity (Bless & Higson-Smith, 1995).

(a) *Content validity*: The topics chosen by social researchers are often extremely complex, with many different components. In order to measure such complex topics properly, the researcher must find a technique which will provide some information on all the different components. When one or more of the components are neglected, the researcher cannot really claim to be

measuring what it is he or she is interested in measuring. Ensuring good content validity is very tedious and, because of this, it is necessary to formulate an operational definition to guide the research and to substantiate the definition on the basis of other research or theory. In most cases this is achieved by referring to literature relating to the researcher's area of study (Bless & Higson-Smith, 1995). In terms of this research the operational definition may be found in the aims set out in chapter 1:

- Exploration of beliefs and opinions held by black traditional healers regarding the concepts of mental illness and mental wellness. Also an exploration of their approach to the promotion of mental wellness

- Presentation of the current, subjective beliefs and approaches of black traditional healers in South Africa as they were related.

- Translation of these subjective beliefs and approaches as they are experienced against the psychological backdrop of the researcher.

(b) *Criterion-related validity*: One way to measure whether an instrument measures what it is expected to measure is to compare the specific instrument to another measure which is known to be valid (Bless & Higson-Smith, 1995). This other measure is known as the criterion measure. If the data collected using the instrument in question closely matches the data collected using the criterion measure, then the researcher may conclude that the new instrument is also valid. In the case of this research, however, the researcher will have to wait for future related research methods against which to measure these

findings. Only then will it be possible to use the data found in this research to predict the results of the criterion measure.

(c) *Construct validity*: It is important that a measurement technique be closely linked with known theory in the area and with other related concepts. Where it is possible to demonstrate such close links the instrument is said to have high construct validity (Bless & Higson-Smith, 1995). In order to attain high construct validity in this research the researcher compiled a list of the different pieces of information that the instrument (in this case a questionnaire) was required to uncover, and the questions were then designed in such a way as to secure this information. By following this process the researcher was able to link the items to the theoretical components of the research topic, thereby contributing to construct validity.

(d) *Face validity*: This has to do with the way the instrument appears to the participant. It is important that an instrument be tailored to the needs of the subjects for whom it is intended (Bless & Higson-Smith, 1995). Sometimes instruments may appear insultingly simplistic and, as a result, certain participants will not take the social scientist or the research seriously. Other instruments may appear far too difficult to the testees, resulting in their giving up before they begin. In the case of the questionnaires used in this research every effort was made to ensure they met the participants' needs in terms of language and ease of understanding. The questions were of an open-ended nature in order to promote individualised and subjective answers from each participant. In order to ensure that the interviewer could explain the questions to the participants clearly

and as objectively as possible the questions were also explained to the interviewer in detail.

CHAPTER 4
FINDINGS OF THE STUDY

4.1 Introduction

This chapter will serve as a presentation of the findings that arose from the completed study. The aim here is to introduce all the findings as they were obtained from the data that was collected. This chapter will be organised in the following manner – each research question will be discussed separately in terms of the themes that emerged from the specific question. Each theme that is presented will highlight the raw data that was utilised to formulate the related theme.

4.2 Research findings from data and feedback

The research findings were extracted from questionnaires completed by each participant. See attached Appendix B and C for the Tshwana and English questionnaires that were given to the participants to fill in.

4.3 Definition of mental wellness – themes arising

The following themes are based on the participants' subjective definitions of mental wellness.

4.3.1 Appearance

- Appearance: There were many indications in the data that it is possible to observe mental wellness in outward appearance. It seems that traditional healers give this priority in distinguishing between a mentally ill and a mentally well person. There is the notion of a person's eyes "*looking all-right*". This notion was discussed during the feedback session and many of the participants agreed that a person whose eyes are "*clear and awake*" is mentally well and functional.

4.3.2 Hygiene

- Hygiene: Several participants commented on an individual's grooming and personal hygiene. Apparently mental wellness is indicated if one is able to wash and wear clean clothes. The traditional healers take the concept of hygiene further than merely personal hygiene – one participant commented that an illustration of being mentally well is "*washing* [the] *children at home*". This opposite of this concept was also debated during the discussion on themes of mental illness.

4.3.3 Communication

- Verbal communication: Forty-six percent of participants mentioned some element of verbal communication during their discussion on mental wellness and mental illness. This has become somewhat of a diagnostic specifier. If a person's verbal communication is clear and understandable, as well as appropriate with regard to the setting in which he or she finds him or herself, then such a person is regarded as mentally well. One participant summarised this concept in his response: "*If person is well he is talking correctly; having an appropriate understandable conversation*." In addition, if a person responds appropriately when spoken to in terms of behaviour this also indicates a sound mind.

4.3.4 Behaviour

- General behaviour: According to the participants certain behaviours are deemed indicative of mental wellness. Interestingly most of these behaviours centre on domestic chores. These activities include behaviour such as the ability to buy the required groceries and other necessities, in other words, being capable of planning financially. Another such behavioural indication is the ability to complete an assigned task correctly. According to traditional healers other chores that are indicative of mental wellness are cooking, fetching wood for the fire,

cleaning the yard and caring for children.

Another element of behaviour that signifies mental wellness is the appropriateness of the behaviour. Appropriate behaviour was often debated by contrasting it to inappropriate behaviour on the part of a mentally ill person – this aspect will be discussed during the themes arising from research question 2, but inappropriate behaviour refers to actions such as talking to oneself, roaming around aimlessly, and undressing in front of people. The dominant view here was that in the absence of inappropriate behaviour, a person may be labelled as mentally well. One participant commented on "*good manners*" as an indication of mental wellness. One of the participants gave the following insightful response regarding the behaviour of a mentally well person: "*A person doing things all-right – he uses his mind to do things right.*" This response indicates the link between mind and behaviour.

- Interpersonal behaviour: The participants mentioned various aspects of interpersonal behaviour that indicate mental wellness. The first important view was that a mentally well person is not "*afraid of people*" – thus suggesting the qualities of being socially well-adjusted and at ease with people (this aspect also relates to mental illness in the form of paranoia and will be discussed during the theme analysis of mental illness). The notion that caring for children indicates mental wellness also translates into the interpersonal sphere of mental wellness, as it indicates a relationship between caregiver and dependants.

4.3.5 Physical health

- Appetite: It was felt that a good appetite indicates mental wellness.

- Physical health: There seems to be a strong belief that there is a link between physical health and mental health. The participants commented several times on physical illnesses or ailments that they view as causes

of mental illness. The participants reported that a person who is physically healthy is very likely to be mentally healthy. They speak of living a "*healthy and active*" lifestyle. The mind-body association of mental wellness was also portrayed in the response of one participant when he described a mentally well person as having "*body activity* [that is] *all-right*".

- Neurological: Epilepsy is often associated with mental illness and the participants believed that should an individual suffering from epilepsy cease to have seizures this would mean the individual was now mentally well. This is another example where a characteristic of mental wellness is described as the absence of a 'mental illness'. Certain participants gave interesting responses to the effect that mental wellness has something to do with a person's 'medulla oblongata' functioning properly. During the feedback session it became obvious that the participants did not know what the exact function of the medulla oblongata was, nor where in the brain it is situated. It became apparent that the use of the term 'medulla oblongata' referred more to overall brain structure. One participant did say that the "*consciousness of a person lives in the medulla oblongata*" and that, if the medulla oblongata is damaged, the person will become mentally ill. There is thus some suggestion on the part of the participants that neurological functioning and structure are in some way connected with mental wellness.

4.3.6 Emotions

- Emotional status: The participants did not say much about which emotions enhance mental wellness, but they again used the contrast of how the absence of certain emotions which are linked to mental illness imply mental wellness. One participant noted that the absence of excessive and inappropriate laughing and/or crying indicates mental wellness – thus implying that controlled, stable emotions are indicative of mental wellness.

4.3.7 Cognition

- Executive functions: Executive functions refer mainly to the higher cognitive functions controlled by the frontal lobes of the brain. These functions include problem solving, planning, organisation, reason, perception of right and wrong conduct, and emotional processing. Cognitive functions were mentioned in various forms in terms of their link with mental wellness. The notion that the ability to shop is an indication of mental wellness could translate into the ability to plan and organise. Appropriate behaviour is managed by the executive functions of the human brain – thus any mention of mental wellness as the absence of inappropriate behaviour implies that proper functioning of the executive functions indicates mental wellness (many of the participants mentioned some aspect of executive functioning while defining mental wellness).

4.3.8 Occupational functioning

There are indications that the participants view good occupational functioning as indicative of mental wellness. For example one participant stated: "*When you give them a task to do, and they do it well, you will see that they are no longer ill*"; and another participant defined mental wellness as "*Doing work well*".

4.3.9 Spirituality

One participant only mentioned spirituality as playing a role in mental wellness. This participant defined mental wellness as follows: "*A good spirit.*" When this was discussed during the feedback session many participants elaborated and agreed that, if a person undergoes the correct rituals before, during and after birth (there are various types of necessary ritual) his spirit will be purified and he will live life with a good spirit. The participants believed that a person with a good spirit will be mentally well, and not susceptible to the various causes of mental illness. One participant mentioned that such a person will be "*normal*".

4.4 Definition of mental illness – themes arising

The following themes are built upon the participants' subjective definitions of mental illness.

4.4.1 Appearance

- Facial expression: Two participants noted that a person who is mentally ill "*will have some changes in his face*". During the feedback session most participants agreed that a person who is mentally ill has a different "*look about him*".

- Poor personal hygiene: Poor personal hygiene was mentioned throughout as indicating mental illness. Participants regard various aspects of poor personal hygiene as a result of poor mental functioning, and during the feedback session they all agreed that poor personal hygiene that has lasted for a substantial amount of time is one of the first warning signs of mental illness. One participant insightfully commented that "*if a man cannot even wash himself, how must he think right about life*".

4.4.2 Behaviour

- Aimless wandering: Aimless wandering was mentioned by several participants as a behavioural pattern synonymous with mental illness. During a discussion on this topic the participants appeared to be divided into two camps: the first group maintained that, if a person is very stressed by problems at home and if it is these problems that are making him or her ill, he or she will tend to roam aimlessly, and not want to stay at home. The other group related better to themes of witchcraft and felt the roaming is similar to a curse – not being allowed to find rest and safety in your home as a punishment for having done something wrong. Either way there was agreement that aimless wandering is a very definite indication of mental illness – for whatever reason.

- Pressure of speech and poor speech content: As has already been discussed many participants commented on some aspect of speech as indicative of mental wellness or illness. It seems that many participants feel that a person who is mentally ill will experience pressure of speech and will have an excessive need to speak. One participant mentioned: "*someone who is talking all the time and he does not know what he's talking about*". Various other responses correlated with this response.

- Destructive and dangerous behaviour as well as criminal behaviour: There were quite a few interesting responses in this regard. It became clear during the research that the participants believed very strongly that involvement in any form of destructive, dangerous or criminal behaviour would result in mental illness. Participants mentioned the following: "*stealing properties…; assaulting other people…; committed an accident to the community*". Certain participants stated that destructive, dangerous or criminal behaviour is the result of mental illness and argued that such behaviour is symptomatic of mental illness. They used this behaviour as a definitive indication of mental illness. The second group of participants described mental illness which results from destructive, dangerous or criminal behaviour in terms of bewitchment. Two participants explained that "*if a person steals things from the community, the community consults with the traditional healer who can mix some ingredients and bewitch the thief – that person will not find rest until he has returned the stolen properties and paid for his mistake to the community*". Certain other participants reported that involvement in criminal behaviour would trouble the person's conscience to such a degree that he or she would become mentally ill.

- Inappropriate behaviour: The participants commented on a broad spectrum of inappropriate behaviours that they believe is indicative of mental illness as they perceive it. These behaviours include walking around naked, undressing in front of people, screaming, talking to

yourself, breaking things unnecessarily, displaying bad manners, urinating inappropriately, and generally doing things "*mixed up"*.

- Unfaithfulness: An unexpected definitive aspect of mental illness is the belief that infidelity is a defining symptom of mental illness. One participant stated: "…*if you are a man who loves more than one woman you will be mad; and vice versa*". Even though this seems to indicate infidelity more as a cause of mental illness, the participants commented during the feedback session that if a person has had many affairs and been unfaithful several times it is very likely that such a person would act in such a way because he or she has been suffering from mental illness for a long time.

4.4.3 Cognition

- Poor executive functions: Executive functions as defined earlier during the discussion on mental wellness were also mentioned during the definition of mental illness. Several participants commented on poor executive functioning as being symptomatic of mental illness. This would include aspects such as poor planning, inability to organise, impulsiveness, loss of inhibitions, and various other types of inappropriate acts.

- Poor attention and concentration: Many participants responded that mental illness relates to being unable to "*think right*". During the feedback session the majority of participants related this back to being unable to concentrate properly and having a poor attention span.

- Disorientation and incoherence: This aspect of mental illness surfaced often during the participants' responses. The idea of disorientation refers to the overall state of confusion that the participants reported seeing in mentally ill people. Various responses in this regard included: "*…without knowing what he/she is doing; … he does not know what he's talking*

about; … wandering around aimlessly; … person does not understand himself".

- Superior intelligence: There seems to be a myth among the participants that a person who is highly intelligent will become mentally ill. They seem to regard it as a given that no overly intelligent person could remain "*normal*" – the idea was put forward that a person who "*knows too much about everything*" would not be able to keep all the knowledge intact. They are of the opinion that at some point the capacity for holding information would be exceeded and then all the knowledge would start "*spilling and mixing so that the person can no longer find understanding – now he will only become mad*".

4.4.4 Emotional

- Excessive introspection: Many of the responses regarding mental illness included references to excessive introspection. The most common description of this excessive introspection was "*Talking too much inside your heart*". This was debated at length during the feedback session and the majority of participants agreed that, if a person is unable or unwilling to verbalise his or her problems and he or she resorts to mulling over these problems "*in the heart"*, it is inevitable that such a person would become mentally ill. They view such excessive introspection as a definitive element of mental illness.

- Flat affect: Some of the responses indicated flat affect as a definitive feature of mental illness. One participant defined a mentally ill person in the following words: "*One whose mind and feelings have been lost.*"

- Isolation: The participants agreed that isolation is a strong determinant of mental illness. One participant explained it in the following manner: "*If you are mentally ill, you will stay a long time without having food. Staying alone – in isolation.*"

- Unresolved problems: This facet of mental illness was mentioned several times by several of the participants. Unresolved problems include various types of problems which a person is not able to resolve. The participants described such unresolved problems as having a causal relationship with mental illness. It is not the type of problem that is important, but the fact that there is no resolution. The participants discussed this among themselves and it became clear that many people who undergo severe trauma and find it possible to talk about the trauma and thus find comfort and resolution often find more solace than a person who is troubled over a long period of time by a miniscule problem for which there is no relief.

4.4.5 Physical symptoms

- Physically sick: The responses indicated that the participants do feel there is some link between physical illness and mental illness, and that the presence of bodily ailments often leads to or increases the possibility of mental illness.

- Fatigue: Fatigue was mentioned as a symptom of mental illness – it is seen both as a symptom ("…*must rest a* lot") of mental illness as well as a cause ("…*working without rest*").

- Not eating or not drinking water: Dehydration and poor appetite was mentioned several times by the participants as signs of mental illness. This aspect was discussed during the feedback session and all participants agreed that, although these factors may cause mental illness (similar to dehydration induced psychosis), they are more often a result of mental illness.

- Neurological disorder: Many participants considered mental illness as synonymous with epilepsy – various participants commented that as long as a person continues to have seizures he or she will be mentally ill.

Another set of responses commented on a person's "*nerves being blocked*" which implies some sort of neurological disease. During the feedback session the participants could not give clear explanations for this aspect of mental illness, but they were convinced that certain types of mental illness are associated with malfunctioning nerves.

4.4.6 Social problems

- Substances: According to the participants substance abuse is a social problem and is thus categorised as such. Certain participants mentioned that there is a strong link between the use of drugs (and other substances) and mental illness. Although the use or abuse of drugs was discussed mostly during the responses on the causes of mental illness, one participant reported that *"[m]ental illness can be caused by JOKO*" (the tea that is available in most supermarkets) during his definition of mental illness. The participant was not clear on whether this would be caused by drinking, eating, inhaling or smoking the tea.

- Abuse or assault: Several participants referred to abuse or assault in their definitions of mental illness. It seems that these are also seen as symptomatic of mental illness. This, however, again implies poor executive functioning, such as impulsivity, poor problem-solving skills, poor judgement, poor conflict management ability and disinhibition.

- Social problems: The term 'social problems' refers to a very broad array of difficulties – most of these were well understood and defined by the participants. Their responses reflected their opinion that social problems are synonymous with mental illness, and are deemed to be both a cause and a result of mental illness. During the feedback session participants deliberated on whether longstanding social problems or very severe social problems could cause mental illness, as well as on the fact that a person suffering from mental illness will experience social problems as a result of his mental illness.

4.4.7 Bewitchment

The theme 'bewitchment' will be discussed broadly during the discussion on causes of mental illness. However, during the definition of mental illness one participant did mention the role of bewitchment in the symptomatology of mental illness.

4.4.8 Spirituality

There is an indication that certain facets of spirituality do relate to mental illness. One participant defined mental illness as a "*spiritual gift*" – referring to mental illness as a positive but complex experience that selected individuals only undergo.

4.5 Causes of mental illness – themes arising.

The following themes are based on the opinions of the participants on the causes of mental illness.

4.5.1 Interpersonal

- Abstaining from sex: Among the participants there was a lot of support for the notion that abstaining from sexual activities is a cause of mental illness. One participant noted that "*if a person does not go with nature – no wife or husband – then the blood goes to the head and you become mentally ill*". However bizarre this might sound to the Western mind, it was a belief well supported among the participants. When this was debated during the feedback session many participants agreed that abstaining from sex does cause mental illness, however, there were many differences of opinion on how exactly this happens.

- No marriage partner: The notion that abstaining from sex causes mental illness was taken further by another participant who referred to the absence of a marriage partner as a cause of mental illness. During the feedback session it became obvious that the participants believed that, if a person lacks a trusting, supportive relationship (similar to the ideal

found in a marriage relationship), it becomes increasingly difficult to manage life's difficulties and, as a result, the person could go insane.

- Unloved by family: The notion that poor family support, rejection within a family or any form of emotional abandonment is a major cause of mental illness was well supported by most of the participants. One participant summed up as follows: "*Problems at home – maybe from husband… or children… not being loved by those at home…*".

4.5.2 Medical

- Blood going to brain: Several responses indicated that if blood comes into contact with the brain this translates into mental illness. This is often described as the result of a motor vehicle accident, head trauma of any sort, or brain damage at birth.

- Poor diet: Participants mention that eating non-nutritional foods, or abstaining from eating altogether, often cause mental illness.

- Smoking: Two participants mention smoking as a cause of mental illness. During the feedback session there was no mention of smoking specific substances.

- Dehydration: Certain participants mentioned that if a person does not drink enough water he or she will become mentally ill. During the feedback session this idea was mentioned and the participants seemed to agree that such cases of 'mental illness' are often of very brief duration. One participant mentioned that "*as soon as such a person is given water and taken to the hospital for a drip, they recover from their madness*". It seems that this refers specifically to dehydration induced psychosis.

- Snoring: Snoring was mentioned as a cause of mental illness. However

none of the participants present during the feedback session could comment on or explain this further.

- Drugs: Drugs were mentioned several times as a possible cause of mental illness. However the participants were unable to name certain drugs or explain their exact effect on mental illness. Most of them did, however, agree that if a person admits to using or abusing drugs that option must be investigated as a main cause of mental illness. If such a possibility has been ruled out, other sources of illness must then be investigated.

- Genetically inherited: A few participants reported that it is not possible to explain mental illness and therefore the only possible reason for it is that it is inherited from parents.

4.5.3 Psychosocial

- Stress: According to the participants stress is a well-documented cause of mental illness. The presence of stress and the comorbidity of poor problem solving or conflict management skills seem to be a rather likely precursor to mental illness. One of the participants reported on the causes of mental illness as follows: "*Problems, person who is not eating well, one who is having a problem without solution (stress*)." All participants appeared to be in agreement that stress is synonymous with unresolved problems.

- Social problems: According to the participants social problems are a major cause of mental illness. Social problems were described by the participants in a variety of ways – "...*drug abuse/use;… lacking something;… stay alone with problems not telling someone to help you;… when being assaulted often;… when you are suffering;… problems at home - maybe from husband, money or children;… not being loved by those at home or at work;… not having basic things*

(food);… home problems;… if there is no peace where you stay - someone not feeling well at home".

- Excessive introspection: As mentioned during the discussion on mental illness excessive introspection was named as a prominent cause of mental illness. "*Mental illness is caused by one who is talking too much, but not by mouth, inside the heart*". This is also sometimes referred to by the participants as "*thinking too much*".

- Suffering: According to the participants suffering refers to the aggregation of painful and/or difficult experiences that a person undergoes during the course of his or her life. This term is often used to refer, not to a specific type of problem, but to a characteristic of life. The participants explained that, although suffering is a part of life, if one has excessive exposure to suffering, or one has to undergo suffering without support from other people, and, if there is no relief to the suffering, it will cause mental illness.

- Overworked: The participants noted that disproportionate amounts of work coupled with inadequate rest may cause mental illness.

4.5.4 Cultural

- Traditional medicines/bewitchment: Most participants commented that, on some level, mental illness is synonymous with bewitchment. Mental illness was often described as intentional punishment for some kind of wrongdoing to another person who then seeks revenge by bewitching the perpetrator. It was also described as the intentional assault of a vengeful or jealous person. Whatever the view it seems that the participants make a distinction between mental illness resulting from bewitchment and mental illness resulting from any other cause.

- Spiritual channel: One participant responded that mental illness is

caused when a person is a "*spiritual channel*". This was discussed during feedback and certain of the participants agreed that, for as long as a person is being used as a spiritual channel, he or she will be inhabited by a spirit force (sometimes ancestral) and, as a result will not act in the same way as he or she had been known to act – the person will talk of strange things and act inappropriately. The participants reported that this is the 'spirit's' way of making his presence known.

- Worm inside the head: There is a myth among the participants that mental illness is caused by a "*worm inside the head*" – none of the participants were willing to explain how this could come about.

4.5.5 Other

- Too much reading: Many participants reported that mental illness is caused by reading too much. This was discussed at length and elicited various anxious responses. Many participants agreed that reading too much causes one's knowledge of the world to expand too fast, causing a type of 'information overload' that may cause the brain to become overburdened and to malfunction. This seems to be related to excessive anxiety.

4.6 Promotion of mental wellness – themes arising

The following themes are a reflection of the participants' opinions regarding the promotion of mental wellness.

4.6.1 Western medicine

- Hospital treatment: The majority of participants reported that mental illness may be promoted by treatment at a hospital. Very few participants expanded on this notion. They did not provide any indication of what usually happens at hospitals to promote mental wellness, only that hospitals are generally associated with "*cure*" and "*healing".*

- Western doctors: Most participants referred to doctors as a homogenous group capable of treating mental illness effectively. However they did not specify the type of doctor or the way in which they contribute to the promotion of mental wellness. One participant only mentioned that mental wellness may be promoted by "…*the hospital, to the doctor who is dealing with the mentally ill person*" – during the feedback session it became clear that he was referring to a psychiatrist.

4.6.2 Traditional medicine

- Traditional healer: All the responses on the promotion of mental wellness presented traditional healers as strong promoters of mental wellness. Although the responses lacked any details on the manner in which traditional healers promote mental wellness, it was clear that the participants regard them as playing a major role.

- Blood medicine: One participant reported that a "*person can be cured by drinking 'blood medicine' and if it does not cure him take that person to Jubilee Hospital to be cured*". Although this response was more concerned with the treatment of mental illness, it was presented by the participant as promoting mental wellness and should therefore be considered as such.

- Other traditional cures: Several responses regarding the promotion of mental wellness referred to various types of traditional cure. These, too, have more to do with curing mental illness, but the participants considered these traditional cures as noteworthy in promoting mental illness – the responses included the following references: "*Coal or wood (like charcoal) pour medicine on that, cover person with blanket so that person can inhale the medicine, after that person is given medicine to drink;… it is our tradition to have the person ingest or inhale something to make him vomit, so that the illness can come out, or that person is put in*

a bath with medication to wash in it;… the cure will be by traditional healers like inhaling medicine or eating medication given by traditional healers…".

4.6.3 Social worker

A few participants referred to social workers as strong promoters of mental wellness. None of the participants elaborated on this idea and therefore no details were provided on the ways in which social workers may be said to promote mental wellness. During the feedback session this was discussed and many participants mentioned that, although they were not sure what social workers did to promote mental wellness, nevertheless social workers were very visible in the sphere of treating the mentally ill. It became apparent that there existed a type of trust relationship between the participants and the social workers whom they encountered in the rural areas where they live and work.

4.6.4 Mental illness literate traditional healer

There were several indications in the responses regarding the promotion of mental wellness that mental wellness may be promoted only by people who are knowledgeable in mental health as such. It was not clear in the written responses whom the participants deemed to be 'literate' in mental illness, and therefore this issue was raised during the feedback discussion. Many participants were of the opinion that it is not just any traditional healer who is able to treat mental illness, and neither can just any kind of Western doctor treat mental illness. They made it clear that traditional healers who are 'literate' regarding the promotion of mental wellness would probably cooperate and liaise with Western doctors in treating the mentally ill. However, there was no clear explanation on how a healer could become 'literate' in the promotion of mental wellness, nor what the criteria are for "*knowing mental illness".*

4.6.5 Adherence to forefathers

The participants indicated that adherence to the wishes of the forefathers could make a considerable contribution to the promotion of mental wellness.

4.6.6 Family activities

The interesting fact emerged that that involvement in family activities plays an important role in the promotion of mental wellness. During his discussion on factors that could promote mental wellness one participant mentioned: "*take a trip with your family*".

4.6.7 Domestic activities

The ability to manage domestic activities was mentioned often during several of the other enquiries, for example the definition of mental wellness. This ability was often referred to as a diagnostic tool for judging mental wellness. However, certain participants also perceived it as a factor which could promote mental wellness. In other words they were saying that involvement in domestic activities could be beneficial to mental wellness.

4.6.8 Spiritual healing

One participant reported that, if a person undergoes spiritual healing, this would promote his mental wellness. This was commented on during the feedback session and the participants agreed that this has to do with accepting a calling from the ancestors to become a traditional healer. They explained that such a calling initially causes symptoms and behaviours similar to those of mental illness, but that the person then undergoes a period of training, and, as soon as that person accepts the calling and receives 'spiritual healing', he will then again revert to a state of being mentally well.

4.6.9 Reading

Reading as a factor that promotes mental wellness proved to be rather a controversial topic among the participants – most participants reported too much reading to be a cause of mental illness (as discussed earlier), however, there were several other participants who disagreed during the feedback session. The first group of participants argued that, if a person is able to decrease the amount of reading he or she does, this would promote mental wellness. The other participants contended that the opposite is true – that a person could gain considerable insight from reading the right kind of literature and this would enhance their mental wellness. It became obvious that reading was regarded as a variable with which to be reckoned in the equation for mental wellness.

4.6.10 Abstaining from drugs

A few participants only mentioned that abstaining from drugs would enhance a person's mental wellness. However, during the feedback session all participants unanimously agreed that abstaining from drugs promotes mental wellness.

4.6.11 Consistency with treatment

The responses on the promotion of mental wellness indicated that if a patient is consistent in the treatment he or she elects to receive – either by a Western doctor or traditional healer – his mental wellness would improve greatly.

4.6.12 Cured in the heart

One participant mentioned that promotion of mental wellness goes hand in hand with emotional wellbeing, which was described as being "*cured in the heart*". This does not necessarily mean that a person has to undergo therapy or something similar in order to attain mental wellness, but the discussion did indicate that a person must be able to manage and balance his or her emotional experiences. The participants

commented that this would include processes of forgiveness, flexibility, problem-solving skills and good conflict management.

4.6.13 No healing

One participant gave an unexpected response to the question of promoting mental wellness: "*A mentally ill person cannot be cured at all. You must admit that you cannot treat that person and the mentally ill person must be as he is. The mentally ill person must believe that one day s/he will be all-right.*" This response was debated during the feedback session and most participants did not agree with this statement. Certain participants provided insightful remarks pertaining to an awareness of one's own limitations – they contended that both traditional healers and Western doctors should realise that it is not possible to treat certain conditions, and that sufferers of these conditions should therefore be referred for another type of treatment or be guided in a process of acceptance of the incurable condition. Other participants noted that there are conditions associated with mental illness that are not well understood in terms of origin, cause or treatment, and that it is important that the person suffering from these conditions not be given false hope.

CHAPTER 5

DISCUSSION OF RESEARCH FINDINGS

5.1 Introduction

The aim of this chapter is, firstly, to expand on the research findings that were presented in chapter 4 by placing them within the context of this specific research, and, secondly, to attempt to compile a summary of the findings as a whole. The pitfalls, unexpected findings and new discoveries that emerged from the data will be examined closely. This chapter will also endeavour to reflect upon how these findings relate back to the researcher's own experiences and psychological background.

The main source of data collection was the questionnaires that were completed by each participant. The questionnaires focused on the descriptions given by traditional healers of the following four aspects: (1) definition of mental wellness; (2) definition of mental illness; (3) causes of mental illness; and (4) promotion of mental wellness. The aim was to obtain subjective descriptions from each participant of his personal opinion of the above aspects.

In the previous chapter the data that had been collected was presented as it had been transcribed and thematically organised from the responses of the participants. There was also some additional information that was collected during the feedback session that was held with the participant group and this information will be discussed first. The feedback session entailed a meeting between the group of participants and the researcher after the data had been transcribed and the themes extracted by the researcher. During this meeting the themes were fed back to the participants to check if they were valid. During this session various uncertainties found in the raw data were debated by the

participants and researcher and this resulted in certain new insights emerging that thickened the research and added to the raw data.

5.2 Discussion of apparent misinterpretations

The raw data reflected that the participants had often misread or misinterpreted certain questions. At first it seemed that certain participants found it challenging to distinguish between the aims of question 1 and question 2, which were supposed to provide comparative definitions – a definition of mental wellness as perceived by the participants versus the definition of mental illness as perceived by the participants. Many participants provided similar answers to both questions. For example, to the question asking what mental wellness is participants provided the following responses: "*That person is not mentally ill, he is healthy*" and "*Person who is not mentally ill is talking, walking all-right and his eyes are looking all-right"*. However, during the enquiry in the feedback session many participants noted that they did not have a detailed perception of the idea of "mental wellness". It became apparent that the only way they could provide a definition of "mental wellness" was by comparing it to "mental illness" and stating it to be the opposite.

At first it seemed as if this problematic aspect would defeat the purpose of this research endeavour which had as its title: "An explorative study: mental wellness as perceived by black traditional healers in the South African context". Thus the focal point of the entire research endeavour was to obtain the participants' perceptions of the concept of mental wellness, and then they responded that they had no such perceptions. However, after spending some time on this thorny issue and relating it back to the literature review as well to as aims of this research, it became apparent that this was indeed a very significant feature of the research findings. If the participants did not have a definition of mental wellness this would impact greatly on their entire perception of, approach to and management of (not only mental wellness) mental illness.

Certain participants seemed totally to misinterpret the term 'mental wellness' and gave responses stating that mental wellness refers to when a person is mentally ill. For example, to the question about the definition of mental wellness they provided the following answers: "*Medication cures"; "Person can be cured by drinking "blood medicine" and if it does not cure him take that person to Jubilee Hospital to be cured"; "Not doing things all-right"; "If you are ill, it means you are healthy, then you are not mentally ill"; "That person is mentally ill"; and "The person is not 100% all-right".* These participants said that they understood the word 'mental' to indicate that there was already something amiss in a person's functioning. These participants reported that they understood the word 'mental" to mean "madness". They all agreed that the term "mental wellness" referred to a person who is still mentally ill, but that the illness was probably no longer of a serious nature. This would impact strongly on the aspects discussed in chapter 2 during the literature review. Black traditional healers focus on the psychosomatic nature of any illness and they also proclaim a holistic approach to understanding illness (Ngong 1998; Kale 1995). It might be that within this holistic, all encompassing approach to health (and specifically mental wellness) important sub-definitions fall away unnoticed and might lead to mistreatment.

In view of the fact that so many of the group's responses came under the perceptions discussed above, it would be safe to say that there is a confused concept of mental wellness amongst the traditional healers participating in this research, and that if a more quantitative study could be conducted to confirm that this is a countrywide phenomenon, it would have far reaching implications in terms of mental health care policy.

5.3 Vague responses

A second aspect that needs to be pointed out is the vague answers given by participants to question 4. These vague responses were grouped in terms of their content similarity and fed back to the participants during the feedback

session. Several participants had, for instance, written that a “doctor” would be able to treat mental illness, but they did not specify the type of doctor. The participants agreed unanimously during the feedback session that every time the word “doctor” had been used, the word referred to a medical practitioner trained in the Western model of medicine. However they did not offer any further classification or distinction between the types of medical doctor and seemed to have a very limited knowledge of the type of doctor who treats mental illness. Only one participant had a vague idea of what a psychiatrist was and responded: “*She is the doctor at Jubilee Hospital who works only with the mad patients – she gives them medicine and if they don’t get better she sends them to Witrand hospital*”.

Most participants knew what a social worker was, and could describe their function very insightfully. There was not a single participant who knew what a psychologist was. After a brief explanation by the researcher on the functions of a psychologist certain participants linked the description to “counsellors”. One participant reported: *“Some of our clients suffering from HIV go to counsellors who help them to accept their status – because it is sometimes difficult for them to accept the HIV and they don’t want other people to know – they are ashamed*”. This was the only response which referred to some form of psychological intervention (even though the participants linked it to HIV counsellors only).

In view of the fact that the participants revealed such a limited knowledge of Western mental health workers, it should come as no surprise that there are so many reports and so much literature exposing the poor referral system which exists between traditional healers and Western mental health workers. It is impossible to utilise someone’s services if you are unaware of his function or scope of work. Also, should a person be referred by a traditional healer to the nearest hospital the question arises as to whom the traditional healer would refer the person? There is a good chance that the person would end up in the general out-patients department of a hospital and be seen by a general medical

practitioner only. It would, therefore, appear that there needs to be a shift in terms of the approach to teaching traditional healers about mental illness, and to provide them with proper information about their partners in the treatment of mental illness (psychologists, psychiatrists, social workers etc.). This would also suggest that traditional healers do not choose to ignore the Western mental health workers because of bias, but that they are very likely unaware of their existence.

5.4 Treatment of mental illness versus promotion of mental wellness

Thirdly, the participants interpreted question 4 as pertaining specifically to the treatment of mental illness and not its promotion. For example: "*You can go to the doctor who will give you medicine"; "Coal/wood (like charcoal) pour medicine on that, cover person with blanket so that person can inhale the medicine, after that person is given medicine to drink"; and "Person can see a doctor to receive medication to cure the illness, it is our tradition to have the person ingest/ inhale something to make him vomit, so that the illness can come out, or that person is put in a bath with medication to wash in it. One can talk to that person so his mind can come again and be all-right".* Very few responses indicated the possibility of a preventative lifestyle alteration that would not only cure, but also prevent mental illness, or the possibility of steps that could be taken to enhance and complement the treatment. Certain participants did mention some of these promotive aspects in answering other questions when describing either mental illness or wellness, or when discussing the causes of mental illness. This seems to tie up with certain of the participants' hazy concept of 'mental wellness' – if they have difficulty defining mental wellness this is likely to overflow into their management and promotion of mental wellness.

During the feedback session the question of promoting mental wellness was discussed at length and many participants stated that their focus is not on promoting wellness, but on curing illness. One participant said: "*We cannot sit*

down with every person that is born and give them what they might need to be well, we perform certain rituals at birth and later and then we must trust that every person will use his own mind and make the right decisions for life. He must also use his elders and his family to guide him through life. When he has failed to do this, it is then that we can provide him with guidance to get him back onto the right road." Based on this type of response and the data collected it is obvious that mental health is treated in a curative, rather than a preventative manner, by the black traditional healers participating in this research.

5.5 Condensed summary of findings

The participants provided a surplus of shrewd opinions regarding other aspects of mental health. The following summary of opinions must by no means be seen as universal – it is based on the subjective findings of this qualitative research and serves only as a condensation of the themes emerging from the data. If traditional healers were to use a 'checklist' to scan for mental wellness or illness (as the Western practitioners utilise the DSM IV-R) this summary would possibly represent most of the indicators.

5.5.1 Defining properties of mental wellness as presented by black traditional healers

A. Mental wellness implies the absence of mental illness.
B. Mental wellness manifests in various visible characteristics:
    1. An overall appropriate and healthy outward appearance is one characteristic of mental wellness.
    2. Good personal hygiene is an indication of mental wellness.
    3. Mental wellness becomes evident if a person is able to communicate fluently, voluntarily and appropriately.
    4. Behaviour that is appropriate, mediated and socially acceptable is indicative of mental wellness.
    5. Physical health is often a prerequisite for mental wellness.

6. The absence of emotional extremes (excessive laughing or crying) is an indication of mental wellness.
7. Cognitively well adjusted individuals, displaying good executive functioning, are seen to be mentally well.
8. The ability to perform occupational tasks correctly and well is seen as a characteristic of mental wellness.
9. A person who possesses a “good spirit” and has undergone the necessary rituals as prescribed by the community/culture is seen to be mentally well.

5.5.2 Defining properties of mental illness as presented by black traditional healers

The following list represents the diagnostic properties utilised by black traditional healers in the ’diagnosing’ of mental illness.

Mental illness is characterised by the following symptoms:

A. Outward symptoms

1. Certain changes in appearance – especially in terms of facial expression
2. Poor personal hygiene

B. Behavioural symptoms:

1. Changes in behaviour such as aimless wandering, destructive behaviour, behaviour that poses a threat or danger to other people, as well as socially inappropriate behaviour.
2. Involvement in criminal activities
3. Infidelity to one’s spouse

C. Cognitive symptoms:

1. Poor executive functions
2. Poor attention and concentration
3. Disorientation and incoherence
4. Superior intelligence

D. Emotional symptoms:

1. Excessive introspection
2. Flat affect
3. Isolation and loss of interest in interpersonal relationships

E. Physical symptoms:

1. A person who is physically sick might be suffering from mental Illness
2. Fatigue
3. Poor appetite
4. Neurological disorders are sometimes a symptom of mental illness

F. Social symptoms

1. Social problems are deemed to be indicative of mental illness

G. Spiritual symptoms

1. Receiving a spiritual gift

5.5.3 Causes of mental illness as presented by black traditional healers:

The following list was presented by the black traditional healers as possible causes of mental illness as they perceive it.

A . Interpersonal causes

1. Abstaining from sex
2. Absence of marriage partner
3. Unloved by family

B. Medical causes

1. Blood going to brain
2. Poor diet
3. Smoking
4. Dehydration
5. Snoring
6. Drug abuse

7. Genetically inherited

C. Social / Psychological causes

1. Stress
2. Social problems
3. Excessive introspection
4. Constant suffering
5. Overwork

D. Cultural causes

1. Traditional medicines / bewitchment
2. Person used as a spiritual channel
3. Worm inside the head

E. Other

1. Too much reading

5.5.4 Promotion of mental wellness as presented by black traditional healers:

The following treatment plans were presented by black traditional healers as possible ways in which to promote mental wellness.

A. Cure by Western medicine

1. Hospital treatment
2. Western doctor

B. Cure by traditional medicine

1. Traditional healer
2. Blood medicine
3. Other traditional cures

C. Cure by a social worker

D. Cure by a traditional healer who is mental illness “literate”

E. Adherence to forefathers

F. Family activities

G. Participation in domestic activities

H. Cure by spiritual healing
I. Reading
J. Abstaining from drugs
K. Consistent treatment
L. A person must be cured in the heart

5.6 Concluding remarks

The above insights should certainly have an enormous impact on the study of mental health/illness as they present information on the theory of mental health as perceived by black traditional healers. We know that our perceptions are closely linked to our worldview and it is therefore important to keep in mind the traditional African worldview as discussed in chapter 2. The crux of the matter is that, according to the African worldview, everything that happens to a person happens for a reason (Ngong, 1998) – it is not always possible to sidestep or prevent this reason – and everything that happens has a role to play in society at large. It is not that traditional healers do not care about promoting mental wellness, it is simply that it is not their focus – their focus is on curing after discovering the cause.

Furthermore, when participants referred to the ability of traditional healers to treat mental illness, they provided very little detail on the types of treatment or the types of traditional healer. When this was discussed with the traditional healers during the feedback session many participants agreed that this information was private and not to be recorded in writing. Many of them reported that it would be irresponsible to write down the types of possible treatment, as an untrained person might try to use one or other of the treatments on him or herself. They also said that they have certain obligations to secrecy as that is part of the effectiveness of their treatment. This is also supported by previous literature and research (Jousse, 2000).

The raw data also presented valuable pointers as to how black traditional healers conceptualise mental illness. The participants' responses to question 2 (definition of mental illness) were frequently based on observable behaviour – a rough description of the symptoms that a mentally ill person would present. The participants did not present encompassing definitions, or enter into lengthy descriptions of the experience of mental illness – the narration was via clear-cut behavioural symptomatology.

Within their definitions of mental illness we find mention of the various areas linked with the symptoms exhibited by a mentally ill person – for example the person's social life, family life, involvement in criminal activity etc. We know already that the African worldview is holistic and all-encompassing – therefore to expect a singular and simplistic cause of mental illness from this group of participants would not be viable (Sue, 1981; Kale 1995).

Many of the responses were based on observable behaviour – that which can be seen. Most other responses commented on those factors that cannot be 'seen', such as bewitchment and ancestral influence. This idea of seeing or not seeing beats a strong rhythm in the participants' perception of mental wellness. It was as if the participants were conveying that there are two main groups of specifiers for the diagnosis of mental illness as perceived by black traditional healers: Firstly symptoms and causes that are visible to the eye (appearance, physical health and social problems) and, secondly, symptoms and causes that are not visible to the eye (bewitchment, spirituality and ancestral influence). It would appear that the emotional and cognitive symptoms of mental illness and the understanding or defining of these vacillate between these two poles of 'seen' and 'unseen – as if their diagnostic placement depends on which of the two (seen or unseen) exerts the strongest influence. It became apparent that the more 'seen' the symptoms and causes the more likely traditional healers are to prescribe treatment by Western medicine (hospital, clinics, doctors and social workers), and, vice versa, – the more 'unseen' the symptoms and causes the more likely they are to prescribe traditional treatment (ancestral communication,

herbal remedies, ‘blood medicine’ and various types of traditional healer consultations).

This pattern of observation was reflected to the group of participants during the feedback session and led to a long debate. The traditional healers also deliberated on it among themselves and reported back that they have a good idea of when a person’s ‘mental illness’ would be better managed by Western medicine and when it would be best suited to traditional medicine. One participant stated: “*I cannot cure Epilepsy, it is for the hospital to treat that person and give her medicine. But if a person is having fits from being called by the ancestors to become a traditional healer, we are learned in the ways to guide such a person*”. This statement could trigger a whole debate on the validity and reliability of such ‘diagnostic methods’, but, although such a debate is important, it is not included in the scope of this research. What is pivotal for this research is that there is a clear distinction between which mentally ill patients are best treated by traditional healers, and which are best treated by Western medicine. The way in which this distinction takes place and which methods are used to determine such treatment plans have yet to be unravelled.

CHAPTER 6

CONCLUSION

6.1 Introduction

The motivation for this research endeavour was to explore, analyse and present the current beliefs as held by black traditional healers treating mental illness and promoting mental 'wellness'. The researcher (who trained as a clinical psychologist) conducted this research from a psychological background. The aim was not to compare the two schools of thought, nor to provide a list of the strengths or shortcomings of psychology and traditional healing in terms of the treatment and management of mental illness or promotion of mental wellness in South Africa. The purpose of the research endeavour was to meet the need to bring substance and dimension to the current beliefs of black traditional healers as told by the healers themselves. More specifically the aim was to provide a descriptive research endeavour into the black traditional healer's definition of mental wellness. This final chapter will attempt to provide a conclusion to the research by summarising the discussion on the research findings. It will then present a reflection of the researcher's experience of the research endeavour, followed by a discussion of the limitations of the research.

6.2 Summarising discussion and statements of research findings

The participants involved in this research provided significant insights into the perceptions and approaches of black traditional healers towards mental wellness. The concept of mental wellness as discussed in chapter 5 revealed itself to be very poorly developed among the black traditional healers participating in the research. It became apparent that their flimsy definition and limited conception of the notion of mental wellness spills over into the manner in

which they approach the phenomenon of mental wellness. The focus of the black traditional healers is on mental illness (or madness as it was often called) and the only way in which they could describe mental wellness was by contrasting it to mental illness.

The participants gave a plethora of shrewd opinions regarding other aspects of mental health. The following summary of their opinions regarding mental illness and its causes is by no means universal – it is based on the subjective findings of this qualitative piece of research and serves only to condense the themes which were extrapolated from the data.

6.3 Reflection

Carrying out research in the field of traditional healing from a psychological perspective constituted quite a challenge. I expected to encounter considerable resistance and not very much cooperation. This negative perception was very probably the result of all the adverse literature that is available on cooperation between Western and traditional healing practitioners. However, I was constantly surprised by the openness and smooth cooperation that I received throughout the research.

I realised I was privileged to receive the opportunity to examine in depth the perceptions and beliefs of a group of people of whom I knew and understood very little. I was obviously the outsider and, as such, was very respectful of their way of life. I had to make peace with several aspects of African culture even before the research commenced. This included allowing for ‘African time’ – many arrangements were postponed, started later than arranged and lasted much longer than anticipated. Surprisingly this never caused frustration – in fact it slotted in perfectly with the underlying approach of this research (qualitative) where the increased research time spent on longer and more in-depth discussions provided rich, thick and full data.

There was a strong realisation that although our (psychology's) paths and vehicles are very different from those used by traditional healers, we are moving towards the same destination – enhancing a person's quality of life.

To be confronted with traditional beliefs, not only in terms of healing, but also in terms of spirituality and world paradigm, was challenging, but never frightening. It was exceptionally rewarding to realise that no black traditional healer would force his beliefs and perceptions on another (not even on me) but would skilfully and respectfully present the alternative treatment and leave the 'patient'/client to decide for him or herself. This was quite different to the experiences I have had many a time in the sphere of Western healing, where the practitioners would rudely expect of the patient to dispose of 'bogus' treatments and haphazardly accept the treatment as presented by 'The Doctor'. It seems Western medicine (and its practitioners) arrogantly believe they are the messiahs in terms of promoting mental health.

I have learned a lot. I made many surprising findings – most of these were written up, but some had to be stored elsewhere as they did not fit into the scope of this research endeavour. It was an experience that facilitated many intellectual journeys, but allowed one to stay grounded.

6.4 Limitations of this research

The research was carried out using a fairly small representative sample of South Africa's black traditional healers and, as we are well aware, there are a lot of cultural adaptations even among the black cultures, so the findings are subjective and not quantifiable. However, this is one of the known limitations when carrying out qualitative research (Malterud, 2001).

Language is always a problem and certain errors do occur during translation. Many responses were very difficult to translate into English and, even during the feedback sessions, when problematic translations were fed back to the

participants with the help of a translator, it was often very tricky to measure the verbatim correctness. Every attempt was made to carry out the most accurate translation, but certain misinterpretations could have occurred.

6.5 Conclusion

Throughout the study conclusive remarks were made as sections of the research were concluded. The most significant of these remarks would probably be that this is but a precursor to a world of research that is waiting to be entered. It is crucial that we use the information gathered in this research and build on it so that it may confidently be used to challenge existing policies on mental health and, even more than that, to challenge the beliefs and perceptions that the Western world of mental health provision holds regarding traditional healing. There are many misconceptions, a plethora of poor definitions, and a myriad of patients suffering in respect of both Western and traditional treatment of mental illness. It would be the ideal to provide a working platform where psychologists and traditional healers could first of all meet and get to know each other, and build up understanding relationships. Only then could they decide whether and how they could work together. This research has made it clear that many traditional healers do not know who and what psychologists are – this could be because they have never met a psychologist. It would be marvellous if psychologists would get off their Western thrones and meet the people who are working hard on the ground to heal a broken society. Maybe then it would be possible for both Western practitioners and traditional healers to enhance each others' perception of and approach to mental wellness.

BIBLIOGRAPHY

Aronson, J. (1994). The pragmatic view of thematic analysis. *Qualitative Report, 2*(1).

Becker, H. S. (1996). *The epistemology of qualitative research*. Chicago: University of Chicago Press.

Bless, C. & Higson-Smith, C. (1995). *Fundamentals of social research methods: An African perspective*. Johannesburg. South Africa. Juta.

Boas, F. (1943). Recent anthropology. *Science*, *98*, 311-314.

Bodibe, C. (1993). What is the truth? Being more than just a jesting Pilate in South African psychology. *South African Journal of Psychology*, *23*, 53-58.

Booi, B. N. (2004). Three perspectives on ukuthwasa: The view from traditional beliefs, western psychiatry and transpersonal psychology. Thesis, Master of Arts, Department of Psychology. Rhodes University.

Buhrmann, M. V. (1986). *Living in two worlds: Communication between a white healer and her black counterparts*. Wilmette, Ill: Chiron.

Chamberlain, J. E. (2003). *If this is your land, where are your stories? Finding common ground.* Toronto, Ontario: Alfred A Knopf Canada.

Charmaz, K. (1990). 'Discovering' chronic illness: using grounded theory. *Social Science and Medicine*, *30*, 11, 1161-1172.

Crotty, M. (1998). *The foundation of social research: Meanings and perspectives in the research process.* St Leonards: Allen & Unwin.

DeWalt, K. M. & DeWalt, B. R. (2002). *Participant observation*. Walnut Creek, CA: AltaMira Press.

Freeman, M. & Motsei, M. (1992). Planning health care in South Africa: Is there a role for traditional healers? *Sociology, Science and Medicine*, *34*(11), 1183-1190.

Giddens, A. (1990). *The consequences of modernity*. Stanford, CA: Stanford University Press.

Grof, S. & Grof, C. (1989). *Spiritual emergency: When personal transformation becomes a crisis*. Los Angeles: Tarcher.

Gunn Allen, R. (1986). *The sacred hoop: Recovering the feminine in American-Indian traditions.* Boston: Beacon Press.

Hammond-Tooke, W. D. (1989). *Rituals and medicines: Indigenous healing in South Africa.* Juta.

Hergenhahn, B. R. & Olson, M. H. (1999). *The person: An integrated introduction to personality psychology* (3rd ed.). New York: Wiley.

Higginbotham, N., Albrecht, G. & Connor, L. (2001). *Health social science: A transdisciplinary and complexity perspective.* South Melbourne: Oxford University Press.

Hirst, M. (1990). The healers art: Cape Nguni diviners in the township of Grahamstown. Unpublished PhD thesis: Rhodes University, Grahamstown.

Holdstock, T. L. (1979). Indigenous healing in South Africa: A neglected potential. *South African Journal of Psychology*, *9*, 118-124.

Jansen van Vuuren, P. (2002). Environmental scanning: A South African corporate communication perspective with special emphasis on the tertiary sector. DPhil thesis, Faculty of Humanities: University of Pretoria,

Jolles, F. & Jolles, S. (2000). Zulu ritual immunisation in perspective. *Africa 70*(2), 230.

Jousse, M. (2000b). 'Oral style', 'memory', and 'the counting necklace'. In P. Denis (ed.), *Orality memory and the past: Listening to the voices of black clergy under colonialism and apartheid.* Pietermaritzburg, South Africa: Cluster Publicationd.

Kale, R. (1995). South Africa's health: Traditional healers in South Africa – a parallel health care system. *BMJ Journals*, *310*, 1254-1256.

Kalweit, H. (1988). *Dreamtime and inner space: The world of the shaman.* Boston: Shambhala Publications.

Kim, U. (Ed.) (1994). *Individualism and collectivism*. London: Sage

Laungani, P. (1992). Cultural variations in the understanding and treatment of psychiatric disorders: India and England. *Counselling Psychology Quarterly*, *5*(3), 231-244.

Leininger, M. M. (1985). Ethnography and ethnonursing: Models and modes of qualitative data analysis. In M. M. Leininger (Ed.), *Qualitative research methods in nursing.* Orlando, Fl.: Plenum Press.

Louw, D. A. & Edwards, D. J. A. (1997). *Extract from psychology: An introduction for students in Southern Africa*. Johannesburg: Heinemann.

Lubbe, B. & Puth, G. (1994). *Public relations in South Africa: A management reader.* Durban: Butterworths.

Makau, K. M. (2003). Counselling across cultures: Experiences of intern clinical psychologists. Master of Arts Dissertation. Department of Psychology. University of Pretoria.

Malinowski, B. (1961). *Argonauts of the Western Pacific*. New York: E. P. Dutton.

Malterud, K. (2001). Qualitative research: Standards, challenges and guidelines. *Journal of Public Health*, *358*, 483-488.

Meissner, O. (2003). Traditional medicine and its accommodation in the South African health care system with special attention to possible statutory regulation. Doctor of Law thesis. Department of Law. University of South Africa.

Miller, J. G. & Miller, J. L. (1992) Cybernetics, general systems theory, and living systems theory. In: R. L. Levine & H. E. Fitzgerald (Eds), *Analysis of dynamic psychological systems (Vol. 1): Basic approaches to general systems, dynamic systems and cybernetics* (pp. 9-34). New York: Plenum Press.

Morse, J. M. (1994). The power of induction. *Qualitative Health Resolution*, *2,* 2-3.

Nevid, J. S., Rathus, S. A. & Greene, B. (1997). *Abnormal psychology in a changing world.* New Jersey: Prentice Hall.

Ngong, R. (1998). The role of traditional medical practitioners. *International Mental Health Workshop,* December.

Nichter, M. (1992). Anthropological approaches to the study of ethnomedicine. Tucson, Arizona: Gordon and Breach Science Publishers.

Patton, M. (1990). *Qualitative evaluation and research methods.* Thousand Oaks, CA: Sage.

Petrus, T. (2006). Engaging the world of the supernatural: Anthropology, phenomenology, and the limitations of scientific rationalism. *Indo-Pacific Journal of Phenomenology, 6*, May.

Pillay, A. L. & Kramers, A. L. (2003). South African clinical psychology employment. *South African Journal of Psychology, 33*(1), 52-60.

Ragin, C. C. (1994). *Constructing social research: The unity and diversity of method*. Orlando: Pine Forge Press.

Ritzer, G. (2000). *Sociological theory* (5th ed.). New York: McGraw Hill.

Rogers, C. R. (1951). *Client-centered counselling*. Boston: Houghton-Mifflin.

Solomon, A. J. (1990). *Songs for the people: Teachings on the natural way.* Toronto, Ontario: New Canada Press.

Solomon, A. J. & Wane, N. N. (2005). *Indigenous healers and healing in a modern world.* Toronto, Ontario: New Canada Press.

Solomon, A. M. (1994). Study of native adolescent males: Their successes in education and life and their familial relationships*.* Unpublished master's thesis. University of Toronto, Toronto, Ontario, Canada.

Spangenberg, J. J. (2003). The cross-cultural relevance of person-centred counselling in post apartheid South Africa. *Journal of Counselling and Development, 81*, 48-54.

Spradley, J. (1979). *The ethnographic interview.* New York: Holt, Rinehart and Winston.

Strauss, A. & Corbin, J. (1998). *Basics of qualitative research: Techniques and procedures for developing grounded theory.* Thousand Oaks: Sage.

Sue, D. W. (Ed.) (1981). *Counselling the culturally different*. New York: John Wiley and Sons.

Taylor, S. J. & Bogdan, R. (1989). *Introduction to qualitative research methods: The search for meanings.* New York: John Wiley and Sons.

Tuckett, A. G. (2005). Applying thematic analysis theory to practice: A researcher's experience. *Contemporary Nurse*, *19*, 75-87.

Van der Heide, G. (2001). Qualitative analysis issues. Presentation: 7th International Health Summer School, Expanding New Horizons in Public Health, Qualitative Research Methods for Public Health Seminar. Queensland University of Technology: Brisbane, 19-23 November.

Visser, M. & Moleko, A. (2005). *Introduction to community psychology*. Pretoria: University of Pretoria Press

Wane, N. (2002). Indigenous knowledge: Lesson from the Elders: A Kenyan case study. In G. B. Hall, & D. Rosenberg (Eds.), *Indigenous knowledges in global contexts: Multiple readings of our world* (p. 54-69). Toronto, Ontario: University of Toronto Press.

Wolcott, H. F. (1995). *The art of fieldwork*. Walnut Creek, CA: AltaMira Press.

Wolcott, H. F. (1999). *Ethnography: A way of seeing*. Walnut Creek, CA: AltaMira Press.

World Health Organisation (2002). *Traditional medicine strategy.* WHO/EDM/TRM/2002.1 (p. 7). Geneva: World Health Organization.

APPENDIX A: Letter of Consent for participating black traditional healers

UNIVERSITY OF PRETORIA
DEPARTMENT OF PSYCHOLOGY

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Contact Details: Tel: 012 – 440 1408
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LETTER OF CONSENT

Title of Study:

An explorative study: Mental wellness as perceived by Black Traditional healers within the South African context.

The aim of this study is to obtain the opinions and beliefs of traditional healers in South Africa as regards their perception of mental wellness in terms of what it is, how it is achieved and how it is hindered.

The benefits of the study are vast – South Africa is already past its 10 years of democracy time span and several societal systems are still functioning quite rigidly and ineffectively. This research might provide valuable new contributions to and suggestions how to change the mental health treatment system of South Africa to the benefit of clients and their families.

The study will entail the use of questionnaires that will be filled out by yourself and other willing participants. These questionnaires will capture currently held beliefs and opinions of traditional healers in South Africa regarding mental wellness and the promotion thereof. The questionnaire will take approximately 20-30 minutes to complete.

These questionnaires will then be analysed and the main themes will be synthesised and written up in the form of a Masters dissertation.

Your identity remains the exclusive knowledge of the researcher and is not captured or disclosed anywhere in the writing of this paper. Your confidentiality is assured as all participants will remain anonymous. Should you decide to withdraw from the research the data collected from you will be destroyed.

Your participation in this research is completely voluntary. Should you feel emotionally or otherwise disturbed during participation in this research you may withdraw at any given time if you so please without any negative consequences.

If you need to contact the researcher for information regarding the research, this may be done by using the details stipulated above or by contacting A.S Moleko directly at (012) 420-2930 at the Psychology Department, University of Pretoria.

_____ _____ _____
Participant signature Date Place

_____ _____ _____
Researcher signature Date Place

APPENDIX B: Questionnaire for black traditional healers - English

QUESTIONNAIRE FOR TRADITIONAL HEALERS IN SOUTH AFRICA

Thank you for participating in this study. All the information submitted in this questionnaire will be treated with the utmost confidentiality and sensitivity.

The aim of this questionnaire is to obtain opinions and beliefs from traditional Healers in South Africa regarding what "mental wellness" means within African traditional healing.

Please read the following questions carefully and answer them as extensively as possible:

1. Please give your definition of "Mental wellness":

2. Please give your definition of "Mental illness":

3. In your experience, what do you think are the causes of mental illness?

4. How can a person promote mental wellness?

THANK YOU FOR YOUR CONTRIBUTION!

APPENDIX C: Questionnaires for black traditional healers – Tshwana

DIPOTSO TSA DINGAKA TSA SETSO MO SOUTH AFRICA

Re lebogela go tsaya karolo mo dipatlisisong. Dikarabo tse o di neelang di tla tsewa jaaka sephiri.

Maikemisetso a dipotso tse ke go itse maikutlo a Dingaka tsa setso mo South Africa gore di tlhaloganya jang pholo ya tlhaloganyo.

Buisa dipotso ka keletlhoko mme o arabe ka botlalo:

1. Pholo ya tlhaloganyo e kaya eng?

2. O kopiwa go tlhaloso gore bolwetsi ba tlhaloganyo/tlhogo bo kaya eng?

3. Ka maitemogelo a gago bolwetse ba tlhaloganyo/tlhogo bo tlhodiwa ke eng?

4. Motho a ka bona pholo ya tlhaloganyo jang?

RE LEBOGELA TIRISANO MMOGO YA GAGO!