

**AN EXPLORATION OF THE TREATMENT OF MENTAL ILLNESS BY
INDIGENOUS HEALERS IN MOLETJIE, CAPRICORN DISTRICT, LIMPOPO
PROVINCE**

by

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DEDICATION

I dedicate this study to my late grandparents, Zachariah Mashatlha and Linah Machuene Lelahane for taking parental role on me and my siblings in our lives. This dedication extends to my late aunt Martha Matlou Ntshwanetša Lelahane who inspired me to believe in myself. May their souls rest in the presence of God our father.

DECLARATION

I declare that **AN EXPLORATION OF THE TREATMENT OF MENTAL ILLNESS BY INDIGENOUS HEALERS IN MOLETJIE, CAPRICORN DISTRICT, LIMPOPO PROVINCE** hereby submitted to the University of Limpopo, for the degree of Master of Arts in Clinical Psychology has not previously been submitted by me for a degree at this or any other university; that is, it is my work in design and in execution, and that all material contained herein has been duly acknowledged.

Surname, Initials (Title)

Date

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Firstly, I would like to thank my savior Jesus Christ for His mercy and grace upon my life and to thank my Prophet T.B. Joshua for being an instrument of heaven that God used to deliver my life, my career and my family. To God be the glory.

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ABSTRACT

Culture affects the way people conceptualise and make meaning in their daily experiences, and in turn influence their decisions to seek solutions to their predicaments. Therefore the definition, causes and treatment of illnesses appear to be perceived in a socio-cultural context. A qualitative study was conducted among the indigenous healers of Moletjie (Capricorn District), Limpopo Province, (South Africa) to explore the treatment of mental illness. Indigenous healers were selected using the purposive sampling after the African Religion/ Culture & Health Forum was consulted and the names of indigenous healers who are members were obtained. 5 males and 5 females were interviewed. Data were collected using semi-structured interviews and analyzed using the content analysis method.

The following psychological themes emerged from the study: indigenous healers' notions of mental illness; perceived causes of mental illness; the process of assessment using the divination bones (*ditaola*); general treatment practices; treatment approaches to psychotic patients; continuous assessment during the treatment process; constant observation of patients during the treatment process; and, treatment procedures that are executed on discharge of the patient.

The findings revealed that there are multiple causalities of mental illness and were accounted for by African traditional beliefs. The study revealed that 90% of the indigenous healers admit patients in their homestead during the healing process but the duration differs. The results further revealed that there are two major treatment modalities employed: namely, the use of herbs and ritual performance. The findings emphasize that treatment of mental illness is mainly determined by the perceived causes which emanate from cultural ideologies.

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APA	6
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CHAPTER 1: INTRODUCTION

1.1 Background to the study

Mental disorders make a substantial contribution to the burden of disease world-wide. For example, the results of a study in a nationally representative sample of the adolescents in the United States of America have shown that the overall prevalence of mental disorders with severe impairment or distress was 22.2% in 2010 (Merikangas, Burstein, He, Swanson, Avenevoli, Cui, Benjet, Geordiades, & Swendsen, 2010). These findings provide the first prevalence data on a broad range of mental disorders in a nationally representative sample of U.S. adolescents. Approximately, one in every four to five youths in the U.S. meets criteria for a mental disorder with severe impairment across their lifetime (Merikangas., et al 2010). Worldwide, mental disorders account for approximately 12% of all disability-adjusted life years lost in 1998 (World Health Organization [WHO], 2000).

In Africa, some studies have suggested that incidents of mental illness could be very high. In Zimbabwe, common mental disorders such as depression mixed with anxiety, are found in over 25% of those attending primary health care services or maternal services (Chibanda, Mesu, Kajawu, Cowan, Araya, & Abas, 2011). Previous attempts to deliver care for common mental disorders through primary care clinics in Zimbabwe although promising in the short-term, had shown little long-term success due to reliance on over-stretched nursing staff and lack of supervision (Chibanda et al., 2011). Problem-solving therapy has been shown to be effective for depression and common mental health problems.

A Zimbabwean team comprising psychologists, a primary care nurse and a psychiatrist adapted existing training materials on problem solving therapy in the light of experience working with lay workers and general nurses in primary care (Chibanda et al., 2011). The treatment appeared acceptable to the community and the lay workers were able to integrate the intervention into their routine work. Preliminary findings also show that the

intervention is efficacious in reducing psychological morbidity, with a drop in score of nearly 5 points on the 14-item psychological outcome scale after 3-6 sessions, and efficacy proportional to the number of sessions attended (Chibanda et al., 2011).

In South Africa, a number of studies have been conducted to investigate the nature and prevalence of mental illness in different settings. A study by Havenaar, Geerlings, Vivian, Collison and Robertson (2008), in Cape Town (Khayelitsha) found that more than one-third (34.9%) of the community sample reported high levels of anxiety or depression symptoms. In an earlier study that investigated common mental health problems in historically disadvantaged urban and rural communities in South Africa, it was found that 27% of the community sample drawn in Limpopo Province showed significant symptoms of depression, anxiety or other common mental health problems, while these symptoms were approximately twice as high in people attending primary health care or indigenous healer services (Havenaar et al., 2008).

According to the South African Depression and Anxiety Support Group, the incidence of depression is even higher in South Africa than the global average (Green, 1996). Whilst it is acknowledged that mental illness is a serious problem, there are very few mental health professionals, like psychologists and psychiatrists to deal with this challenge. In 1965, there were 70 psychiatrists registered with the South African Medical and Dental Council. This number rose to 302 by 1977 and by 2012 it was close to 400, which is still insufficient for a population of about 50 million (Gillis, 2012).

A study by Gillis (2012) found that even though there has been a marked increase in the number of practising psychiatrists in recent years in hospital and private practice in South Africa, the shortage for the mental health professionals is still acute, especially in rural areas. Currently, there are 7 148 registered psychologists and 350 psychiatrists in South Africa. These figures appear insufficient for a population of about 50 million they are expected to serve (<http://www.hpcsa.co.za>). What this situation suggests is that the ratio of psychologist to the population is 1: 6 995, which is considerably too low.

With such a low number of professionals, namely psychologists and psychiatrists, it is evident that many people will seek alternative services for mental health elsewhere. The World Health Organization (WHO) estimates that up to 80% of people in Africa make use of indigenous medicine (Stafford, Pederson, Van Staden, & Jäger, 2008). The South African national Department of Health (DOH) has estimated that there are more than 200 000 indigenous healers active in this country alone (Kale, 1995). They have flourished in the face of competition from modern medicine. About 200 000 indigenous healers practise in South Africa, compared with 25 000 doctors of modern medicine.

Indigenous healers in South Africa greatly outnumber those who practise modern medicine and it is believed that there are 80 000 such healers and about 350 doctors in neighbouring Mozambique (Kale, 1995). African indigenous health approaches have evidence of more relative success in treating mental health conditions than physical conditions (Mpofu, Peltzer, & Bojuwoye, 2011). Indigenous healing is preferred for its accessibility and affordability and also important attributes as well as its philosophy of seeing the person holistically rather than through a Cartesian divide (Chan, 2008).

According to Abbo (2011), an indigenous healer present in every village bears the burden of the community's mental illnesses. However, it was recently estimated that there is at least one indigenous healer for every village and four out of five Ugandans visit indigenous healers, particularly in rural areas (Abbo, 2011). In Africa, indigenous healing is part and parcel of African traditional beliefs. People in Africa have close relationships with indigenous healers, who often share the same community and culture. Meissner (2003) reminds us that traditional medicine will not go away. Black indigenous healers existed in South Africa before colonization by the Dutch in the 17th century.

As is evident in South Africa and other African countries, indigenous and faith healers play an important role in health care (Peltzer, 1987; 1998; 1999; Shai-Mahoko, 1996; Sodi, 1998). This is based on the suggestion that for many South Africans, the first choice of treatment is the indigenous healer (Farrand, 1984; Louw & Pretorius, 1995;

Mabunda, 1999; Swartz, 1986). Nonye and Oseloka (2009) conducted a study to establish the treatment seeking behaviour of patients suffering from mental illnesses in the south-eastern part of Nigeria. The study showed that psychiatric consultation is not usually initially employed, especially in rural areas. The study further indicated that the most common first contact for treatment of mental illnesses is the prayer house (34.5%), followed by a psychiatric hospital. The majority of patients in that study attributed their ailments to supernatural causes, which explains why visiting a spiritual house was their first option. It is these kinds of studies that have motivated the present researcher to explore how indigenous healers treat mental illness in Moletjie, Capricorn District, Limpopo Province.

1.2 Research problem

Cultural or indigenous knowledge systems regarding healthcare, or traditional healthcare approaches and methods have been in existence since time immemorial. In most African countries, healing systems for mental health problems are pluralistic and include indigenous, religious and allopathic theories and practices (Zondo, 2008). People do use indigenous healing and allopathic medicine together and even simultaneously, but sometimes without the knowledge of their doctors (Zondo, 2008). A large proportion of the African population uses indigenous healers pluralistically alongside Western biomedicine and psychiatry (Kahn & Kelly, 2001).

Indigenous healers hold powerful positions in their communities because they act as physicians, counsellors and psychiatrists (Hewson, 1998). Madu (1997) stated that because traditional Africans perceive the cause of sickness (either emotional or psychological in nature) to originate from some form of punishment from the gods for the individual concerned evil deeds; therefore Western-influenced models of psychotherapy have limited cache. There are also the overarching systems of values and norms, which help perpetuate patterns of mental health (Idemudia, 2004).

A study by Mufamadi and Sodi (2010) about the notions of mental illness by VhaVenda indigenous healers in the Vhembe District of Limpopo Province found that heredity, witchcraft, sorcery, disregard of cultural norms and spirit possessions were regarded by the indigenous healers involved in that study as some of the causes of mental illness. Another study conducted by Mufamadi (2001) in Venda, Limpopo Province, revealed that indigenous healers are in a unique position to understand and to heal the illness of their patients because they have a thorough knowledge and understanding of the history of their patients and they also share similar customs and beliefs. Healing by indigenous healers includes two interrelated functions providing effective control of the disease and illness manifestations, and attributing personal and social meaning to the experience of being ill in a particular cultural setting (Mufamadi, 2001). In these two particular studies the focus was on the treatment of mental illness in a Vhavenda community. The current study will focus on Sepedi speaking indigenous healers in Moletjie, Capricorn District, Limpopo Province.

1.3 Aim of the study

The aim of this study is to explore the treatment of mental illness by indigenous healers in Moletjie, Limpopo Province.

1.4 Objectives of the study

The specific objectives of the present study were:

- To determine the types of mental illness identified by indigenous healers in Moletji, Limpopo Province, and
- To understand and describe the methods used by the indigenous healers in the treatment of mental illness.

1.5 Operational definition of concepts

- **Indigenous healers:** According to Xaba (2002), a traditional healer is a person who engages in indigenous medical practice. The practice is considered indigenous because a practitioner invokes African conceptions of cosmology and cosmogony to effect healing and well-being. An educated or lay person who

claims to have the ability or healing power to cure ailments, or a particular skill to treat specific types of complaints or afflictions and who might have gained a reputation in his/her own community or elsewhere. He/she may base his/her powers or practice on religion, the supernatural, experience, apprenticeship or family heritage (Ahmed, Bremer, Magzoub & Nouri, 1999). In some literature, an indigenous healer is referred to as a traditional healer. In the present study, the two concepts (i.e., indigenous healer and traditional healer) will be used interchangeably to refer to the one and the same person.

- **Mental disorder:** The American Psychological Association (APA) defines a mental disorder as a clinically significant behavioural or psychological syndrome or pattern that occurs in an individual and that is associated with present distress or disability or with a significantly increased risk of suffering, death, pain, disability, or an important loss of freedom. The word mental disorder and mental illness concepts will convey the same meaning and in this study, they will be used interchangeably.

CHAPTER 2: LITERATURE REVIEW

2.1 Introduction

In this chapter, I start by reviewing the literature on some of the historical views on mental illness. The second part will focus on some of the popular western views regarding the causes and treatment of mental illness. In the third part of the chapter, I will briefly review some literature on some of the common African cultural views on mental illness. In the fourth and last part of the chapter, I will focus on some of the popular theoretical perspectives on mental illness including the theoretical framework that I have adopted to guide me in this study.

2.2 Historical perspectives on mental illness

There is good reason to speculate that mental illness has existed from the beginning of the history of human beings. However, in terms of the history of western medicine, the Greek physician Hippocrates (460-377 B.C.) is considered the founder. He suggested that psychological disorders could be the effects of psychological and interpersonal contributions to psychopathology, such as negative effects of family stress (Barlow & Durand, 2009). According to Holmes (1994), it is the work of Hippocrates that influenced Kraepelin in the late nineteenth century to develop the first truly comprehensive classification of mental disorders, which subsequently paved the way for the World Health Organization's International Classification of Diseases and the American Psychiatric Association's (1994) Diagnostic and Statistical Manual, which is now in its fifth version.

The Roman physician Galen (129-198 A.D.) later adopted the ideas of Hippocrates and developed them further, and extended them well into the 19th century. His approach is the humoral theory of the disorders (Barlow & Durand, 2009). In 1854, John P. Grey became editor of the *American Journal of Insanity*, the precursor of the current *American Journal of Psychiatry*, the flagship publication of American Psychiatric Association (APA). Under Grey's leadership, the conditions in hospitals greatly improved and they became more humane, livable institutions. By the end of the 19th

century, leaders in psychiatry were alarmed at the increasing size and impersonality of mental hospitals and recommended that they be downsized and that was the inception of the controversial policy of deinstitutionalization, in which patients were released to their communities (Barlow & Durand, 2009).

In the early years of the twentieth century, Emil Kraepelin (1904), the father of modern Western psychiatry, noted that the patients in North America and Asia failed to express their illness with the prototypical symptoms characteristic of his patients in Germany and Northern Europe. Puzzled by this situation, Kraepelin suggested a new speciality within psychiatry be created to study cultural differences in psychopathology. (Marsella & Yamada, 2000). It is ironic that Kraepelin, who was, like many 19th-century psychiatrists, committed to a biological view of mental illness should be among the very first to note the importance of cultural differences in the frequency and expression of disorders (Marsella & Yamada, 2000).

Marsella and Yamada (2000) discovered that during the emergence of postmodernism and related changes in intellectual thought, realities (including scientific ones) are all culturally constructed. They further added that knowledge in psychiatry and the social sciences is culturally relative, and as such, it is ethnocentric and biased. What passes for truth is, in fact, a function of who holds the power. Those who are in power (e.g., Western psychiatry) have the "privilege" of determining what is acceptable, and those who are not, are marginalized in their opinion and influence (Marsella & Yamada, 2000). Within the last few decades, psychiatry and the other mental health professions and sciences (i.e., anthropology, psychology, sociology, public health and social work) have increasingly acknowledged the critical importance of cultural factors in mental illness (Marsella & Yamada, 2000; Sodi & Bojuwoye, 2011).

The history of psychiatry in South Africa stretches back to the first settlement by Europeans in the Cape of Good Hope in 1652. Its development falls into 3 phases with some overlaps. The first was a period of expediency and restraint during the early stages of the occupation of the Cape by the Dutch East India Company; the second, which could be called the psychiatric hospital era, was under the control of the British

from the earlier part of the 19th century towards the beginning of the 20th century; and the third, broadly speaking, is the modern period since then (Gillis, 2012). Psychiatric diagnosis did not exist, and the mentally ill, lacking an obvious physical cause, were simply called “insane”, “mad” or “lunatic”, the latter because of the supposed effects of the moon. They were largely thought to be possessed by demons which could be dispersed by “alienists”, an appellation which endured well into the late 19th century (Gillis, 2012).

It is interesting to note that the concept of mental illness as a disease only came about towards the end of the 18th century, and the term “psychiatry” was coined by a French physician in 1808 (Gillis, 2012). It is reported that living conditions in the early years were dreadful; “buildings were decrepit, overcrowded and verminous; patients lived in squalor and management was unfeeling”. It was quite usual to find them kept in dark insanitary cells, filthy, covered in festering sores and chained to iron rings (Gillis, 2012). Treatment did not exist as such; it was purely a matter of ensuring the safety of the person and controlling violent or disruptive behaviour (Gillis, 2012).

The situation changed towards the end of the 19th century when it became clear that temporary lock-up and restraint arrangements and containment in police cells were not adequate, or in keeping with current ideas. Under the apartheid regime, strict legislation concerning separate facilities and accommodation for black patients was enforced but, as from 1991, transformation and consolidation began in some hospitals and led to the total abolishment of racial distinctions when a new government came to power in 1994 (Gillis, 2012).

Mainstream psychology is predominantly a Euro-Americocentric science which was exported to Africa with the result that to date a specific personality theory from a purely African perspective has not been developed (Meyer, Moore, & Viljoen, 2003). A lot of work taking the African perspective into account has been done on pathological behaviour with the pioneering work of Vera Buhrmann (1977, 1979, 1984 & 1987) in which she did extensive studies on traditional healing methods among the Xhosa and pathological behaviour among Africans. An overarching perspective based on

indigenous concepts capturing the essence of an African psyche does not exist (Meyer et al., 2003).

2.3 Western perspectives on mental illness

Western psychological theories have consistently perceived mental illness as maladaptive behaviour that is largely caused by a person's inner psychic disturbances. For example, the psychodynamic theories assume that mental illness is a result of unconscious psychological conflicts originating in childhood. Sigmund Freud, the founder of this theoretical perspective, believed that both normal and abnormal functioning is motivated by irrational drives (which are sexual in nature) that are determined by childhood experiences (Freud, 1914). He further suggested that psychological disorders are caused by an imbalance in the structures of personality, (namely, identity, ego and superego).

It is interesting to note that the concept of mental illness as a disease only came about towards the end of the 18th century, and the term "psychiatry" was coined by a French physician in 1808. Historically, Western psychological practice relies heavily on natural science whilst ignoring the role that social conditions, power relations and societal institutional arrangements play in shaping peoples' conceptualization of illness, health, healthcare and associated help-seeking behaviours (Angelique & Kyle, 2002; Vijver, & Leung, 2000).

2.4 African cultural views on mental illness

The African view of mental ill-health currently encompasses a wide spectrum – from ancestors, folk belief and witchcraft, to modern medical science (Mkize, 2003). All the systems function simultaneously within the African culture and within the individual and easily fit and complement one another (Mkize, 2003). This view also fits well into the bio-psycho-social model. The African patient does not consider the illness as something to be cured or controlled, but as something to be understood and acknowledged. It is no longer a matter of explaining the mechanisms in order to control them, but of understanding the significance (Mkize, 2003). Disease is not just a physical condition,

according to African interpretation and experience, but is also a religious matter (Mbiti, 1996). For the African therapist, on the other hand, the symptoms are manifestations of a conflict between the patient and other individuals, dead or alive, spirits, and the non-material forces that pervade society (Mkize, 2003).

Sodi and Bojuwoye (2011) have argued that culture is an important factor in healthcare and that each culture has its own unique conceptualization about illness, health and healthcare. All cultures have their own unique explanatory models of health and illness that can be understood within their respective worldviews (So, 2005). Therefore each culture has its own conceptual model of explaining illness (So, 2005). Such attitudes and beliefs about mental illness can only be studied within a cultural context (Kabir, Lliyasu, Abubakar & Aliyu, 2004). In most traditional African cultures, disturbed social relations are perceived to create disequilibria expressed in the form of physical or mental problems (Juma, 2011).

All cultures of the world have different unique ways of explaining illness and of bringing health to the people. Thus, according to Shweder and Bourne (1982), the Western-oriented conceptual framework reflects only a minority view among the cultures of the world. Leventhal and Nerenz (1985) mentioned that when individuals face psychological problems, they represent the problem along five dimensions, which include identity (label), perceived cause, time line (how long it will last), consequences (physical, social and psychological) and curability/controllability. These representations are drawn from social norms about the illness. There are also three types of attribution that people make to mental illness such as psychological, somatic or normalization of the illness. All these are embedded in culture. Culture is therefore a strong determinant of people's perceptions of illness, its perceived causes and treatment options as compared to other personal attributes (Shai, 2012).

In the study conducted by Kabir et al., (2004) in Karfi village, northern Nigeria, the respondents have mentioned that aggression/destructiveness, talkativeness, and eccentric behaviours were the most frequently perceived symptoms of mental illness. Divine punishment was also associated as a perceived causative factor of mental illness

(Kabir et al., 2004). Many individuals are of the belief that one evokes supernatural wrath by taking intoxicants, thus leading to the development of mental illness (WHO, 2001). In a phenomenological study of indigenous healing in a Northern Sotho community, Sodi (1998) found that indigenous healers attach culturally-congruent labels to clusters of physical and psychological symptoms presented by their clients. Diagnosis is linked to the patient's culture.

Bankowski (1996) explains that in most traditional African societies, mental illness can also be thought to be induced by human beings by means of sorcery, witchcraft, magic or by divine agents like departed ancestors and angry gods. While trying to provide explanation for the relationship between culture and health, Harkness and Keefer (2000) observe that health or illness are culturally defined and treated, since cultural meaning systems inform aspects of illness as some diseases are culturally specific.

In a study conducted by Ventevogel, Jordans, Reis and De Jong (2013) in three African countries (that is, South Sudan, the Democratic Republic of the Congo and Burundi) on the concept of mental illness, several challenges arose when studying "local concepts" of mental illnesses. Firstly, local knowledge is continually reproduced and evolving and is often somewhat idiosyncratic, and context dependent. In all four areas, respondents described supernatural forces as a causal factor for conditions related to severe behavioural disturbance. A second challenge is how to define "mental illness". Indigenous African categories of misfortune may not consider mental illness a separate, or distinct category from other "non-medical" forms of misfortune, such as marital problems, failure to prosper or poor performance at school because the definition of what constitutes mental illness are influenced by cultural and other contextual factors, and change over time (Ventevogel et al., 2013; Whyte, 1997).

A recent survey in a small town in western Ethiopia, reported bio-psychosocial problems such as poverty, stress and drug abuse to be believed as important problems for mental illness besides religious/magical views such as God's will or attack by evil spirit (Mulatu, 1999). The concept of mental disorder is determined by many factors, including the historical context, cultural influence, level of scientific knowledge and capacity to carry

out scientific enquiry, level of education in certain circumstances, as well as many others (Njenga, 2007). Many Africans still view gay and lesbian people as "mentally sick", because their sexual orientation is against the order of nature. It therefore stands to reason that the concept of what is and what is not a mental disorder is a dynamic one, which will change from time to time, from culture to culture and, as in the case of homosexuality, from generation to generation (Njenga, 2007).

The study conducted by Kleinman and Sung (1979) (cited in Mufamadi, 2001) suggested that indigenous healers' view of the disease is usually more in line with the patients' beliefs than is the Western medical conception of disease. Secondly, the indigenous healer treats both the "invading ghost" (disease), as well as the symptoms and the psychosocial problems (illness) produced by the disease. In many parts of Africa, mental illness is understood to be present when an individual shows behavioural signs and symptoms that are perceived to deviate from the traditional social norms (Mufamadi & Sodi, 2010). Beneduce (1996) in his study found that speaking loudly, even in the presence of the elders and the refusal to be with others of his/her own age group is considered by the Dogon of Mali as some of the symptoms of mental illness. Other symptoms of mental illness identified by Beneduce (1996) include aggression, laughing and singing in a loud voice, immodesty and incoherence.

According to Chavunduka (1994), in Zimbabwe a person is considered mentally ill if he/she performs foolish acts without realizing what he/she is doing. Other symptoms include restlessness, violence, and proneness to accidents. In a study conducted by Mufamadi and Sodi (2010), some cases of mental illness were interpreted as invitations that ancestors make to people who are destined to become indigenous healers. Bodibe (1992) found that mental illness and physical afflictions are caused by failure by the living to follow the instructions of the ancestors. In the study conducted by Wessels (1985), it was suggested that some people may be driven by jealousy or evil intentions to harm others by afflicting them with mental illness.

According to an indigenous African perspective, illness is complex and multifaceted. It incorporates religion, spirituality and kinship, biological and socio-ecological influences (Zondo, 2008). The African conception of illness is based on African ideologies of the self as a relational self, which is captured by the African saying, "I am because we are or *umuntu ngumuntu ngabantu*," referring not just people who are living but inclusive of spiritual beings in the form of ancestors and God (Zondo, 2008). In the study conducted by Zondo (2008) in Kwazulu-Natal, only one in ten respondents mentioned biological factors, trauma or stress as potential causes of mental illness. Nine (9) percent of the participants further felt that mental illness was a form of punishment from God and six (6) percent perceived poverty to be the major cause of illness.

For example, a study conducted by Gureje, Lasebikan and Oluwanga (2005), on a Yoruba-speaking Nigerian sample, indicates how mental illness is mainly attributed to evil spirits, which signal the discordance between the individual or the family with particular members of the community. According to the African conception of illness, diagnosis is then first aimed at identifying the root cause of the distress. Illness further serves as a tool for the ancestors to communicate or convey a message to the living (Hewson, 1998; Melato, 2000). The message is mainly that of dissatisfaction because of bad relations between family members or between the ancestors themselves and the family.

Conceptions and perceived causes of illness by Africans influence decisions regarding the appropriate steps to take in dealing with distress. Illness is both a biomedical and spiritual phenomenon and as a result traditional healers are consulted to explain the meaning of the disease for that particular person (MacKain, 2003). According to Cheikhyoussef et al., (2011), there are several advantages for people in rural areas in opting for indigenous medicine: indigenous healers are usually found within a relatively close proximity to their homes, they are familiar with the patient's culture and environment, and the costs associated with such treatments are generally negligible. Such talented individuals are believed to possess awareness or knowledge, skills, values and attitudes acquired through timeless experiences and wisdom for helping people solve problems and make decisions (Lee & Armstrong, 1995).

Srinivasan and Thara (2000) found that patient's gender and education, duration of illness, education, and the nature of relationship were associated with family beliefs about the cause of mental illness. Most Africans believe that both physical and mental diseases originate from various external causes such as a "breach of a taboo or customs, disturbances in social relations, hostile ancestral spirits, spirit possession, demoniacal possession, evil machination and intrusion of objects, evil eye, sorcery, natural causes and affliction by God or gods (Idemudia, 2004).

Pearce (1989) also argued that it is too simplistic to conceptualise disease as something physical, which attacks the body. According to him, disease causation can be due to "things we see and things we don't see" (pp 47). He further postulated that many of the things we do not see are included in African belief systems, cultural and social values, philosophies and expressions. On the other hand, the conceptualisation of depression (including the associated help-seeking behaviours) in many sub-Saharan Africa communities take into account the spiritual, social and cultural factors (Sodi, 2009; Swartz, 1997).

According to Tsala-Tsala (1997) every disease is systematically acknowledged as having a supernatural origin - the grief of ancestors or divinities, the practice of sorcery and various evil spells. To an African, biology alone does not explain disease causation because it is seen as a social phenomenon; and as such has the significance for the whole ethnic group and the immediate community members (Idemudia, 2004). The common element in the African belief system is simply that physical and mental illness is the result of distortions or disturbance in the harmony between an individual and the cosmos, which may mean his family, society, peers, ancestors, or a deity (Idemudia, 2004). According to Tsala Tsala (1997), this way of viewing health and disease, as a matter of harmony or disharmony between an individual and a larger context is similar to the holistic perspective being advanced currently by Western researchers.

Nzewi (1989a) has documented the emphasis placed on good/moral behaviour and social harmony in the etiology of health among the Ibos of Nigeria. African societies (Yorubas and Ibos of Nigeria; Hehe of Tanzania, Luo in Kenya, and the Amhara in

Ethiopia) believe that disruptive behaviour and the breaking of taboos are punishable through misfortunes and ill-health. Nzewi (1989a) also went further to classify the different psychopathologies in the Ibo culture. Mentioned among the severe were: "Onye nla" (mad person), "Isi Mmebi" (diseased head), "Isi Mgbaka" (sour head), among the non-severe types were: "Agwu" (possessed), "Akaliogoli" and "Efulefu" (indicating some personality disorders of different types).

In Africa, people interact with one another not on the basis of how things are, but how they perceive them. As Kleinman (1980) has pointed out, patients and healers have their own "explanatory models", that is, their particular understanding of what a human being is and how psychosocial disorders that may appear are to be accounted for and treated. According to the South African study conducted by Sorsdahl, Stein, Grimsrud, Seedat, Flisher, Williams, & Myer (2009), it was found that in many traditional African belief systems, mental health problems are perceived as due to ancestors or by bewitchment, and indigenous healers and religious advisors are viewed as having expertise in these areas. According to Mdleleni (1990), Mzimkulu (2000) and Ngubane (1980), "*amafufunyana*" which is described as an extreme form of depression with psychotic features (including hysteria and suicidal tendencies) is explained in terms of spirit possession.

From an African perspective, conflicts in interrelationships, killing animals that the community consider sacred or cutting sacred trees may cause an individual, family or community some health problems (Juma, 2011). From a traditional African perspective, ill health is manifested in physical diseases (microbiological infection) or psychological-mental illnesses, as well as a breakdown in social and spiritual mechanisms of the individual and the community (Juma, 2011). Juma (2011) in his study, found that guilt and worries of not adhering to cultural norms will make the individual sick mentally, physically or both. According to Sogolo (1993), cultural norms are important as in the following example: if an African man is involved in an adulterous act with his brother's wife, whether or not this act is detected, he will undergo stress as it is perceived that he has disturbed his social harmony.

2.5 Theoretical perspectives on mental illness

2.5.1 Biomedical theory

This model explains the illness on the basis of aberrant somatic bodily processes such as chemical imbalances or neurophysiological abnormalities. Bio-medicine is usually associated with diseases of the physical body only and Western medicine or biomedicine is often contrasted with the approach taken by indigenous 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. Therefore, illness with no structural biological evidence is dismissed. Effective treatment changes the physical state of the body in such a way as to correct the physical cause of illness. For example, depression will be diagnosed through biological indicators such as measurements of neurotransmitters, changes in brain chemistry and overall decrease in brain activity (Bland, 1997; Keller, 2003).

Although the biomedical model has benefits for studying some diseases, this model has some shortcomings. Rather than recognizing the role of more general social and psychological processes, the biomedical model is essentially a single-factor model. It explains illness in terms of a biological malfunction rather than recognizing that a variety of factors, only some of which are biological, may be responsible for the development of illness. The biomedical approach is limited even when applied in Western cultures because it neglects the subjective nature of the illness as well as cultural and contextual influences (Shai, 2012).

The biomedical model fails to account why a particular set of somatic conditions need not inevitably lead to illness and others are psychological and social factors that influence the development of illness, and these are ignored by the biomedical model. Whether a treatment will cure a disease is also substantially affected by psychological and social factors, and this cannot be explained by the biomedical model (Suls & Rothman, 2004).

2.5.2 Psychodynamic theory

Psychoanalysis, like the rest of modern medicine, is centered on the concept of a failure of certain mechanisms within the individual. This model was formulated based on Freud's theory of psychoanalysis. To the psychoanalyst these mechanisms are inherent in the patient's personality, which in turn reflects his history and in particular his childhood. This model postulates that there are specific unconscious conflicts that can produce particular physical disturbances that symbolize repressed psychological conflicts. For example, in conversion hysteria, the patient converts the conflict into a symptom via the voluntary nervous system and he or she then becomes relatively free of the anxiety. (Berzoff, Flanagan, & Hertz, 2007). This model does not recognize other factors such as social and environmental factors to contribute to the causes of illness.

2.5.3 Family systems theory

These theorists postulate that psychopathology does not reside in the individual, but rather in a disturbed system of family relations. They share the fundamental, underlying assumption that there is a troubled family system and also pathology arises as a function of poor boundaries among family members (Goldenberg & Goldenberg, 2008). The model maintains that all levels of organization in any entity are linked to each other hierarchically, and that change in one level will affect other levels.

2.5.4 Theoretical framework for the current study: Bio-psychosocial model

This is the theoretical framework that guided the researcher in the present study. The model maintains that biological, psychological and social factors are all important determinants of health and illness. Both the macro level processes for example, the social support or the presence of depression and micro level processes such as cellular disorders or chemical imbalances interact to produce a state of health or illness (Abbo, 2011). The bio-psychosocial model maintains that health and illness are caused by multiple factors and produce multiple effects. The model further maintains that the mind and body cannot be distinguished in matters of health and illness because they both clearly influence an individual's state of health. The bio-psychosocial model emphasizes

health and illness rather than regarding illness as a deviation from some steady state. From this viewpoint, health becomes something that one achieves through attention to biological, psychological, and social needs rather than something that is taken for granted.

Engel (1980), the founder of the model in 1977, maintains that the process of diagnosis should always consider the interacting role of biological, psychological, and social factors in assessing an individual's health or illness. Therefore, an interdisciplinary team approach may be the best way to make a diagnosis (Suls & Rothman, 2004). This model further maintains that recommendations for treatment must also involve all three sets of factors. The bio-psychosocial model clearly implies that the practitioner must understand the social and psychological factors that contribute to an illness in order to treat it appropriately. In the case of the ill individual, biological, psychological, and social factors all contribute to recovery.

These recommendations emphasize the need to better understand and utilize linkages among biological, psychological, social, and macro cultural variables. Activities that facilitate the adoption of a multi-system, multi-level, and multi-variate orientation among scientists, practitioners, and policymakers will most effectively lead to the kinds of trans-disciplinary contributions envisioned by the bio-psychosocial perspective (Suls & Rothman, 2004).

More recent studies from Ethiopia showed inclusion of biological and psychosocial factors as causes of mental disturbances in addition to the age old spiritual and magical views (Teferra & Shibre, 2012). But besides the religious/magical views, there were prominent bio-psychosocial causes reported: biological causes such as malaria, traumatic brain injury, epilepsy, and alcohol and khat abuse; psychosocial stressors such as the experience of child birth, severe psychological stress and thinking too much were reported time and again by the participants as major causes of mental disturbance.

“Thinking too much”, which was repeatedly mentioned across the groups as cause of mental disturbance, is a finding consistent with reports from Zimbabwe by Chibanda et al. (2011), which found a similar attribution style referring to less severe forms of mental distress such as the non-psychotic conditions referred to as worry (Teferra & Shibre, 2012). African perspective of illness encompasses the physical, spiritual and social dimensions of the individual (Meyer et al., 2003).



Figure 1: The biopsychosocial model (Source: Dr Foster)

The bio psychosocial model is an approach that believes biological, psychological (which entails thoughts, emotions, and behaviors), and social factors, all play a significant role in human functioning in the context of wellness or illness (Dr.Foster, n.d.). Psychosocial factors can cause a biological effect by predisposing the person to risk factors. An example is that depression by itself may not cause lung problems, but a depressed person may be more likely to have smoking or alcohol problems, and therefore lung or liver damage might develop. Perhaps it is this increased risk-taking that leads to an increased likelihood of disease. All these three factors interact with each other and sometimes perpetuate the illness.

CHAPTER 3: RESEARCH METHODOLOGY

3.1 Introduction

This chapter focuses on the research methodology, which includes research design, sampling, participants, data collection method and data analysis.

3.2 Research design

In this study, a qualitative research approach was used. Qualitative research has been recognized as a legitimate way to obtain knowledge that might not be accessible by other methods and to provide extensive data on how people interpret and act on their symptoms (De Vos, Strydom, Fouche, & Delpont, 2005; Smith, Pope & Botha, 2005).

3.3 Sampling

The sample for the study was recruited and drawn from indigenous healers in Moletjie area (Capricorn District) belonging to the African Religion/ Culture and Health Forum. The participants were selected through purposive sampling after the indigenous healers' forum was consulted. This means that sampling depended not only on availability and willingness to participate, but also on suitability and appropriateness of the cases (Terre Blanche, Durrheim, & Painter, 2006). Through this sampling process a total of ten (10) indigenous healers participated in the present study.

3.4 Data collection

A semi-structured one-to-one interview was conducted at the location suitable to the participants. According to (De Vos et al., 2005), semi-structured one-to-one interviews gave both the researcher and participant more flexibility; it was also suitable where the researcher was particularly interested in complexity or process, or where an issue was controversial or personal. Interviews were open-ended, conducted in Sepedi—the language preferred by the participants in order to gain a detailed picture of the participant's beliefs about or perceptions of a particular topic and was translated by two different translators. Data were captured by use of a tape recorder and written notes. According to (De Vos et al., 2005) a tape recorder allows a much fuller record than notes taken during the interview.

3.5 Data analysis

Analysis of data was the process that brought order, structure and meaning to the mass of collected data. According to Marshall and Rossman (1999), data collection and analysis typically go hand in hand in order to build a coherent interpretation of the data. Content analysis of the data was done following the steps below represented by a spiral image (De Vos et al., 2005).

STEP 1: Managing (Organising) data

This was the first step in data analysis and as the first loop in the spiral, it begins the process properly. In the early stage of the analysis process, researchers can organize their data into file folders, index cards and also convert their files to appropriate units.

STEP 2: Reading and writing memos

During this phase, the researcher read the transcripts several times, so as to get familiar with the data, and get a feeling of the whole database. The researcher immersed herself in the details trying to get a sense of the interview as a whole before breaking it into parts. During the process, the researcher performed some necessary editing to make filed notes retrievable and generally “clean up” what seemed overwhelming. Memos were written in the margins of field notes or transcripts. These were in the form of short phrases, ideas or key concepts that occur to the reader (Creswell, 1998).

STEP 3: Generating categories, themes and patterns

From what the researcher did in the previous phase, salient themes were identified, and recurring ideas or language and patterns of belief that link people and situations together and the meanings held by participants in the setting were categorized. Here are the psychological themes that emerged: a). Indigenous healers' notions of mental illness; b). Perceived causes of mental illness; c). The process of assessment using the divination bones (*ditaola*); d). General treatment practices; e). Treatment approaches to psychotic patients; f). Continuous assessment during the treatment process; g).

Constant observation of patients during the treatment process; h). Treatment procedures that are executed on discharge of the patient.

STEP4: Testing emergent understanding

Part of this phase entailed evaluating the data for their usefulness and centrality. The researcher was able to determine how useful the data collected were in illuminating the questions being explored and how central they were to the story that was unfolding about the social phenomenon being studied.

STEP 5: Writing the report

This was the final phase of the spiral image, in which the researcher presented the data, a packaging of what was found in the text. The report was in a written form which remained the primary mode for reporting the results of the research.

3.6 Reliability, Validity, Objectivity

Credibility

The researcher adequately placed boundaries around the study by adequately stating the parameters such as the variables, the population and theoretical framework (Lincoln & Guba, 1985).

Transferability

In this study, the researcher used multiple methods of data collection such as, interviews and tape recordings as well as note taking.

Conformability

The researcher involved several investigators or peer researchers to assist with interpretation of the data at different times or locations, so as to improve the analysis and understanding of construction of others (Lincoln & Guba, 1985).

3.7 Ethical considerations

The following are the most important ethical issues which were considered in this research:

3.7.1 Permission of the study

The researcher sought and obtained permission from the University of Limpopo Research and Ethics Committee before the study was undertaken.

3.7.2 Informed consent

According to Dyer (1996), research participants are entitled to be fully informed about the aims, reasons and purpose of the study. The researcher informed the participants on what would happen to the data generated. In line with this ethical principle, the researcher explained the significance of the study before conducting the study. The participants were given a consent form which was explained to them first before it could be signed by both the participants and the researcher. The participants were informed that participation was voluntary and that they could withdraw at any stage they wished.

3.7.3 Confidentiality/anonymity and privacy

Full confidentiality, privacy and anonymity were maintained throughout the study. No personal information was required. The tape recordings and notes taken during the interview were accessed only by the supervisor and the researcher. The researcher assured the participants that in all the documents numbers would be used rather than names.

3.7.4 Respect for persons

Dignity and integrity of the participants were ensured throughout the study, and it was explained to the participants that their participation was neither to violate them nor to use them to achieve the researcher's goals, but the intention was to learn from them and their knowledge could contribute to the development of our country. For the purposes of the study, pseudo-names were used.

CHAPTER 4: RESULTS

4.1 Introduction

In this chapter, the researcher will first present the demographic profile of the participants. This will be followed by content analysis of the protocols obtained from the participants so as to extract the psychological themes that emerge. In this regard, the following themes that emerged will be presented:

1. Indigenous healers' notions of mental illness
2. Perceived causes of mental illness
3. The process of assessment using the divination bones (*ditaola*)
4. General treatment practices
5. Treatment approaches to psychotic patients
6. Continuous assessment during the treatment process
7. Constant observation of patients during the treatment process
8. Treatment procedures that are executed on discharge of the patient.

The chapter will conclude by giving a summary of the results of the study.

4.2 Demographic profile of participants

Table 1: Demographic details

Partici pant's no	Age	Gender	Home language	Residential area	Marital status	Experience of practicing	Educational level
1	49	Female	Sepedi	Masehlong	Single	12 years	Grade 8
2	70	Female	Sepedi	Flora	Married	30 years	None
3	73	Male	Sepedi	Ga- Mabitsele	Married	33 years	None
4	43	Male	Sepedi	Ga-Chokoe	Married	8 years	Grade 5
5	50	Male	Sepedi	Ga- Rapitsi	Married	21 years	Grade 3
6	50	Female	Sepedi	Ga- Kolopo	Single	25 years	Grade 1
7	55	Male	Sepedi	Ga-Kolopo	Married	20 years	Grade 4
8	72	Female	Sepedi	Marowe	Married	26 years	None
9	66	Female	Sepedi	Marowe	Married	24 years	None

10	37	Male	Sepedi	Ga-Phaudi	Married	5 years	Grade 10
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The sample of this study comprised ten (10) participants who are indigenous healers in Moletjie area (Capricorn District) belonging to the African Religion/Culture and Health Forum. There were 5 males (50%) and 5 females (50%). Seventy percent (70%) of the participants were over the age of 50, suggesting that mental illness was mostly treated by the elderly than the young generation. Four of the participants never went to a formal school, whereas four attended school but terminated while still in the lower grades (that is, between Grade 1 and Grade 5) and two managed to attend high school up to grade 8 and 10. The majority of the participants (80%) were married and were staying with grandchildren as their own children had moved out to stay with their own families. Only two indigenous healers who participated in the study were single and had children staying independently in their own homes. The diversity of the sample was beneficial for the study because the rich knowledge from different perspectives on mental illness was obtained.

A number of the healers expressed a need to have more assistants who would help them in the management of patients. Some indigenous healers pointed out that they preferred to treat their patients during school holidays so that they could utilize the services of their own relatives as assistants during treatment. It was found that the majority of the indigenous healers (70%) had been treating mental illness for over 20 years, with the longest serving indigenous healer having been in practice for 33 years. Five years was reported as the shortest period in practice by the indigenous healers who participated in the study. This suggests that the majority of the indigenous healers have been practising for a fairly long time and could thus be considered to be credible sources of information on the treatment of mental illness.

4.3 Content analysis of the data

4.3.1 Indigenous healers' notions of mental illness

Although the concept of mental illness appeared to be well understood by the participants, they seemed to struggle when they were asked to define this condition.

Most of the participants (60%) equated mental illness with madness, thus giving the impression that mental illness is conceptualized and understood as a fairly serious psychopathological condition. This conceptualization of mental illness as serious psychopathology is reflected in the following extracts by some of the participants:

"The blood goes to the brain and confuses the brain and we call that madness".
{Participant 1}

"Mental illness is madness. Yes. .. By madness I mean one does not even know who they are, where they come from or where they are going". {Participant 2}

"I know it to be madness which is when a person can no more be in control of himself but he is controlled by the state in which he is". {Participant 3}

"Mental illness is a mixed up condition of your mind". {Participant 4}

"Yes. Mental illness is when someone speaks and does things he doesn't understand, doesn't know whether he is coming or going and we call it a trance".
{Participant 5}

"Mental illness is high blood pressure when it attacks the head". {Participant 6}

"Mental illness is when there is lot of blood in the brain to the level that it can no longer bear the pressure and lose control..... Yes. I simply say a person is mad".{Participant 7}

"I understand it to be spirit possession..... Yes. And such a person we call mad person". {Participant 8}

"I know it to be madness..... I mean loss of self-control" {Participant 9}

“I know it to be confusion and loss of mind”. {Participant 10}

It can be deduced from the above statements that the participants conceptualize mental illness as a condition that is manifested through a patient’s loss of contact with reality. In other words, someone with mental illness will show significant levels of disorientation in terms of time, place and person. The descriptions give the impression that mental illness is what could be described in Western psychology as a psychotic condition.

4.3.2 Perceived causes of mental illness

Most of the indigenous healers who participated in this study, (60%) were of the view that there are many causes of mental illness. Being spiritually disconnected with the ancestors was seen as one of the main causes of mental illness. The following extracts illustrate this causal explanation:

“Another cause may be when parents stop communicating with the ancestors, fighting in the family then the ancestors get offended and cause someone to be sickThe person might speak to himself and walk aimlessly”. {Participant 6}

“The illness can also be caused by a person refusing the call by ancestors..... Ancestors can wish that someone obey an instruction like being a healer or becoming a sangoma and some people refuse.....Yes. Then they are able to make that person go mad and does not understand what he does because his mind is lost” {Participant 5}

“This illness can be caused by the evil spirit of someone who died.....But that spirit is brought about by other people and the victim catches a trance.....Sometimes the victim is able to see the spirit put into him but only him can see that”..... {Participant 4}

The above extracts suggest that the ancestors have the power to inflict mental illness to the living if they feel ignored. In this case, the illness becomes a way for the ancestors

to communicate their displeasure to the living. The indigenous healer appears to play a unique and very important role of being able to decode the messages from the ancestors to the living.

A few other indigenous healers indicated that biological factors like heredity and medical conditions that are not treated during childhood can complicate into mental illness. A few conditions identified to be a result of biological factors include epilepsy and childhood illness known as lekona. The view expressed by a number of indigenous healers was that a child should receive preventative treatment immediately after birth. Failure to do so could result in the development of conditions like epilepsy and *lekona* later in life. In the case of epilepsy, recurrent convulsions that are unsuccessfully treated can lead to disorganized behaviour and speech, resulting in mental illness. The following statements reflect the above sentiment:

“The illness can be caused by ‘seebana’ I mean “valsiek” (epilepsy) can complicate into mental illness.....when a person falls many times, he ends up not thinking properly and starts hallucinating, speaking to himself in a nonsensical language”. {Participant 5}

“Sometimes it (mental illness) can be caused by failing to cure ‘hlogwana’ or ‘lekona’.....yes, it means they did not treat the person traditionally while still a young child”. {Participant 6}

“Yes. Or someone can be born with the illness”. {Participant 1}

It was also found that some indigenous healers consider psychological factors as the possible causes of mental illness. These psychological factors included excessive worry, thinking too much and stress. According to the indigenous healers, people whose mental illness is a result of psychological factors will show symptoms like tearfulness, suicidal ideation, social withdrawal, loss of control, confusion and mental derangement. The extracts below reflect this particular view regarding the causes of mental illness:

“Even stress can cause this illness.....A person may have problems and start thinking deeply until his mind is not able to take the stress.... Such a person can cry for no reason, he may prefer to stay aloof from other people... others even think of committing suicide”. {Participant 5}

“You know even thinking too much can make one’s mind get tired.....Yes. Then the mind is mixed up and cannot function properly”. {Participant 8}

“With others it is caused by mental stress.....When a person is confronted with a problem he can’t solve, his mind works hard until exhaustion takes control of the mind”. {Participant 7}

“Mental illness can again be caused by the change of seasons of the year.....A person gets mixed up in the mind as a result.....Yes, more especially during autumn in the month of September”. {Participant 4}

Substance abuse was also mentioned as a possible cause by few of the indigenous healers who participated in the study:

“Other causes might be smoking of marijuana and other things like Nyaope and nails mixed with Ratex for killing rats”. {Participant 4}

“With others it is caused by dagga smoking.....Yes. You see when someone smokes dagga for too long it affects his mind and can no more think properly”. {Participant 8}

Witchcraft was perceived as one of the causes of mental illness. The element of jealousy seemed to be a major motivating factor leading to witchcraft against the targeted individual to ensure that the individual’s future and potential was hindered. This belief is conveyed in the following statements:

“Further it may be caused by witchcraft.....People can make one mixed up and start picking up papers and rubbish in the streets...Yes. Mostly jealousy causes this witchcraft”. {Participant 8}

“Furthermore it can be caused by stealing after which they bewitch you.... With others it is caused by witchcraft after someone committed murder.... Yes. Someone may go to bewitch others in their homes and the intended witchcraft gets back to them.” {Participant 10}

“People can bewitch someone by casting the spell on somebody and do something they prescribe and a person starts presenting with unusual behaviour like picking up papers in the streets and roaming around”. {Participant 5}

“Yes, it can also be caused by food poisoning..... Some jealous people can put poison (seješo) in someone’s food and after swallowing that he gets mixed-up and becomes mad”. {Participant 3}

Another interesting finding of the study was what seemed to be the ability of the indigenous healers to differentiate between the symptoms of mental illness depending on the causal factors thereof. For example, some indigenous healers indicated that they were able to distinguish a patient suffering from a mental illness that is caused by witchcraft when compared to someone whose mental illness is caused by substance abuse. This is illustrated in the extracts below:

“People whom mental illness was caused by substance use are perceived to be presenting with hearing voices, and sees things others don’t see or hear, he/she smells things alone and starts picking up rubbish and stops sleeping.....The patient can be very dangerous as they are hyperactive and I even talk of them having “malkrag”.....Such a person is easily angered as his feelings are caused by what he smoked”. {Participant 4}

“Those whom their illness was associated with stress, are perceived to cry for no apparent reason, he/she may prefer to stay aloof from other people.....And others even think of committing suicide to be free from that mental distress”. {Participant 5}

“Symptoms that are perceived to be caused by witchcraft when someone steals and the people bewitch the place with muti so that thief must run mad.....Such people start speaking to themselves about the stolen goods and tell everybody about what they did”. {Participant 10}

“People can make one mixed up and start picking up papers and rubbish in the streets”. {Participant 8}

“Just then the bewitched starts mixing up speeches, the gait and mind also change, he walks without knowing where he’s going and doesn’t sleep well any more”. {Participant 2}

Based on the above explication, it can be suggested that indigenous healers perceive mental illness to be a result of many causes. These include disconnectedness with the spiritual world, witchcraft, psychological factors, biological factors and substance abuse. The indigenous healers further pointed out that they have the capacity to diagnose the underlying cause(s) of mental illness based on the symptoms that the patient has.

4.3.3 The process of assessment using the divination bones (*ditaola*)

It does appear that most of the indigenous healers use divination bones (*ditaola*) to arrive at a diagnosis of a patient’s problems. The main objective of the process of assessment is for the indigenous healer to seek to establish the nature of the problem that has brought the patient for consultation. This is illustrated by the following extracts:

“Now when he is settled we throw the bones and ask the ancestors what the cause is and what medication to administer”. {Participant 9}

“Then I start throwing the bones to ask the ancestors what his problem is, what caused it and how it can be healed”... {Participant 1}

“The healer now uses the bones when the patient is relaxed so that he must be well-diagnosed..... The healer talks to the ‘badimo’ (ancestors) to find out the cause of the illness..... {Participant3}

From the above extracts one can deduce that ancestors are perceived as very important and central in the diagnostic activities that the indigenous healer engages in. Spiritually guided by the ancestors, the indigenous healer arrives at a diagnostic formulation that, among others, reveals the root cause of the distress and the treatment that would be relevant. The indigenous healer would then interpret the messages received from the ancestors and convey that to the patient and the relatives in a language that is more understandable to the patient.

Apart from using the divination bones to diagnose the clinical condition, it does appear that these diagnostic instruments are also used by the indigenous healer to identify the particular treatment modality that is appropriate for the patient. For example, the herbs that the indigenous healer is expected to use to treat a particular type of mental illness will be determined through the use of the divination bones. The ancestors are also perceived to play an important part in helping the indigenous healer to prescribe the correct medicines. The following quote illustrates what is described above:

“The healer starts diagnosing the illness by using the divination bones to ask from the ancestors about the cause of the illness, which medicine to give to him and how the patient should he be treated” {Participant 4}

“Again the ancestors (badimo) give us advice as to what can be done to manage the illness”.... {Participant3}

The indigenous healers indicated that apart from *ditaola*, they can also observe how the patient presents to them and establish that the individual is ill. Additionally, they pointed out that patients are not supposed to reveal their problem to them. Instead, the indigenous healer reveals what the patient's problem is, as reflected in the following extracts:

“Initially when someone arrives at the indigenous healer, they must not say what their illness is.....I, as a healer will realise from their face that they differ from normal people as they talk too much and they are restless..... They run their eyes all over as if they see things that other people don't see”. {Participant 1}

“You see someone who comes in brought by people and all chained up and wearing dirty clothes is not normal... by just looking at him or her, I know the person is sick mentally”. {Participant 7}

Based on the above, it can be suggested here that *ditaola* serves a critical diagnostic role in the management of mental illness. These diagnostic instruments also help the indigenous healer to determine the appropriate treatment that should be considered for the patient with mental illness. According to the indigenous healers, the diagnostic power of the divination bones is enhanced by the intervention of the ancestors.

4.3.4 General treatment practices

Most of the indigenous healers (90%) who participated in this study prefer to admit the patients in their homestead during the period of treatment. They indicated that the healing process of mental illness is long and therefore patients are admitted for a period of a week to six months depending on the progress of the illness. Some patients are stabilized and thereafter are treated from their homes under the care of their families. The main idea for admission is to enable the evaluation of the effectiveness of the treatment. Other indigenous healers indicated that they believe that a patient should be treated at a different place than home to reduce the severity of the illness.

“Yes, I treat all my patients from their own homes but some can be here for one week only until they become better before they go home now that they will agree to drink the medication”. {Participant 3}

“All patients are admitted so that they must be checked regularly..... But if someone was ill say more than a year, even the healing will take time. The indigenous healer can observe changes whether you are improving or not. And again another reason is for the patient to change places and be at a different place from where the illness was contracted.....that is very important because we believe that he might deteriorate when he is at home”. {Participant 4}

“Another thing is that the patients are all admitted here and stay with one of their relatives so that they are able to prepare food for them... Yes. That’s because he doesn’t know us and he takes us as enemies”. {Participant 7}

This arrangement often entails stabilizing the patient for some days or a week and then discharging him/her to continue with the treatment at home. The duration of treatment ranged from one day to six months. Their main objective for admitting the patient in the homestead is to ensure treatment compliance, proper use of medicine and monitoring of the progress of the patient closely. Treatment procedures could be perceived as mainly directed at the individual patient so as to restore his/her level of contact with reality. Some indigenous healers indicated that they are at times compelled to restrain uncooperative patients for the purpose of administering some of the treatment. For example, an uncooperative patient may be restrained when he/she is expected to take some medication through steaming or smoke inhalation.

It was found that there are two major modalities that the indigenous healers follow in the treatment of patients presenting with mental illness. These treatment modalities are the use of herbs and the performance of rituals. Herbs can be taken orally or through bathing, smearing, steaming and smoke inhalation. It is believed that the herbs will force out the illness from the body and also to chase out the spirits that are causing mental

illness. Other methods of taking the herbs that were mentioned by the indigenous healers included incisions on the skin, sniffing and inducement of vomiting. The following extracts illustrate how herbs are used in the treatment of mental illness:

“When such people arrive at the healers place, they are given the wild medicine called ‘mošimanyana wa nageng’ to smoke like ‘snuff’ in the nostrils so that the patient must sneeze and will get tired and sleep”.... { Participant 5}

“We bathe his head while standing in the river, and he speaks out that the illness should flow with the river and never come back”. {Participant 8}

“The patient starts by steaming with the herb called ‘matswane’ mornings and evenings and also bathing with a buck of chopped up aloeHe also gets to drink boiled medicine called ‘molebatša’ mixed with the root of ‘morula’ tree”. { Participant 5}

“Yes, I cure all my patients from their own homes but some can be here for one week only until they become better before they go home..... Now that they agree to drink the medication”. {Participant 3}

“Yes. Like every morning and evening they steam up, drink the medication and bath”. {Participant 7}

The healers reported that mentally ill patients would be given “*muti*” or herbs to drink, bath with or to inhale the smoke . They also described treatment involving sniffing herbs through the nose and smoking herbs like cigarette.

As was indicated earlier, the second treatment modality involves the performance of some rituals. In this case, the family of the patient, including community members may be invited to enjoy the meat of the slaughtered animal that was sacrificed to appease the ancestors. The indigenous healers also reported that the ancestors are summoned

to come closer so that their relationship with the patient can be re-established and strengthened. As a symbol of the strengthened relationship, the patient will be expected to wear a small piece of the skin of the slaughtered animal as a wristband. This practice is interpreted to mean that the patient treated recognizes the omnipresence of the ancestors. The following extracts illustrate the points above:

“Mostly they want them to slaughter a goat or cow to propitiate the ancestors. The person must be introduced to his/her ancestors and a wrist band made of goat or cow skin be prepared for the person to wear on the wrist and we say he/she is wearing sethokgolo”. {Participant 6}

“When we are through and the illness was brought by the ancestors, we explain that to the family and to the patient if he/she can understand..... A cure for such is for the patient to agree to the calling.....If the person agrees then we start training the person to become a healer and others only need the suppression of ‘malopo’ and they are released”. {Participant 10}

Some indigenous healers suggested that they can at times refuse to provide their services if, in their assessment, they find that the potential patient has evil intentions. This happens in cases when the potential patient is suspected of being a witch or when such a patient has the potential to harm others. It was further pointed out that indigenous healers stand the risk of contracting the same mental illness themselves if they ignore the potential risk associated with treating a patient that has evil intentions. The following statements illustrate this:

“Those who are witches, murderers and thieves I don’t help them because even if I can, the illness will come to me”. {Participant 10}

“But I don’t handle those who stole from others and those who are bewitched from their actions..... If I help them they will recover but their illness comes to me..... That’s because they offended others and they retaliated”. {Participant 9}

It does appear that there are instances when a patient may become violent or refuse to take his/her treatment. In such cases, the indigenous healer will engage the services of others to restrain the patient and to administer the appropriate treatment. This is illustrated in the extracts below:

“Others refuse inhalations and steaming. ...Yes.... But I request his relatives to help me hold him down to force him to inhale the smoke but after one week he/she will agree on his own by himself”. {Participant 1}

“All patients refuse to inhale the smoke but we force them until after a week when they agree to do it”. {Participant 10}

“But it is difficult as others refuse to drink.....But we force them and even a little medicine can make them vomit.....Once he vomits he is able to sit down without fighting”. {Participant 3}

Few of the indigenous healers reported that they do consult with colleagues in cases when the patient shows poor progress or when the condition deteriorates. For example, one indigenous healer reported that she prefers to refer a patient to a colleague whom she considers to be more experienced if she realizes that the patient is making poor progress. In some cases, she would refer some of the patients showing poor progress to the hospital. The following extracts illustrate this point:

“If my healing to a patient seems not to work I consult with other healers to get help and even ask for herbs if I don’t have If I realize that there is no improvement I send them to my colleagues so that I don’t keep a patient here when there is no progress, or I refer him/her to the hospital”. {Participant 9}

“If the illness is caused by failure to cure children’s diseases, I do try to help them..... I start by attending to ‘lekona’ (childhood illness) even on grown-ups below the age of ten but if he is older than ten he is incurable.....I just tell them immediately that they need to visit the hospital”. {Participant 6}

“In many cases those born with the disease are difficult to treat and I refer them to the hospital”. {Participant 1}

It can be deduced from the above extracts that indigenous healers do admit some patients in their homestead for treatment. The two major treatment modalities that the indigenous healers use are herbs and the performance of rituals. It was also found that indigenous healers can exercise their right to refuse administering treatment to individuals who pose a threat to others through their evil intentions or deeds. In cases where the indigenous healer feels that he/she is not adequately skilled, there is provision to refer patients to colleagues or to the hospital. This suggests that indigenous healers are amenable to working collaboratively with their colleagues or with Western trained health care practitioners.

4.3.5 Treatment approaches for more psychotic patients

The findings from the study suggest that the more psychotic or violent patients are approached differently in terms of treatment as compared to other patients. The indigenous healers appear to be able to differentiate the presenting symptoms of psychotic patients from non-psychotic patients hence the rationale for a different approach on treatment. Some of the psychotic patients coming to consult will come being handcuffed because of their violent behaviour. In these kinds of situations, the indigenous healers appear to be mindful about the safety of these patients and the team that will be treating the patients.

When patients present with psychotic symptoms like pressure of speech, hallucinations, aggressive or destructive behaviour, the indigenous healer's immediate therapeutic goal appears to be that of stabilizing the condition. The quiet atmosphere created when the patient is stabilized allows the indigenous healer to communicate with the ancestors and to interact with the patient's relatives to propose a treatment plan. The following extracts illustrate what is described above:

“Mostly these mentally disturbed patients will be restless when they arrive at the healer's place, refusing to sit down, mixed up and beating people...Some are fastened with ropes or chains, or they speak uncontrollably.those kinds are hit by a stick that is smeared with 'morara'..... The indigenous healer must hit the patients immediately as others may be dangerous and can injure helpers and relatives ...Then he will relax and sit down ... If he was fastened, we release him and he will never fight anybody and he agrees to everything he is told”. {Participant 2}

“A bewitched patient who comes here fastened and speaking nonsense... With them before we diagnose we boil medication made from ground seeds of 'mokhure' and give him a drop in the mouth ... Once he swallows it, then the indigenous healer can release the ropes and the patient will sleep quietly until the following day. Even if he does not sleep, he will be settled” {Participant 10}

“But others come here very restless and speaking a lot. Under such conditions I smear a whip with 'ditshemo' and mix with 'morara' and 'molebatša'Then I strike the patient so that he relaxes and sits down”. {Participant 9}

Based on the above extracts, it can be deduced that indigenous healers are able to identify psychotic or violent patients and to implement appropriate intervention strategies to stabilise them. It can therefore be argued that indigenous healers perceive themselves as having the necessary skills and expertise to handle unstable patients and to create a conducive environment that will promote treatment. This suggests that

indigenous healers have some specialized knowledge on how they classify and prioritize their patients, based on the clinical picture that the patient presents with.

4.3.6 Continuous assessment during the treatment process

While the process of healing continues, the indigenous healer continues to receive guidance from the ancestors on how best to treat the patient. It was found that the indigenous healers consider this continuous liaison with ancestors as a central vehicle to bring about positive change in their patients. Through this arrangement, the indigenous healers pointed out that they were able to closely monitor patient progress and to ensure that treatments (herbs) are changed frequently until the prognosis was satisfactory. The indigenous healers emphasized that due to the prolonged treatment period for mental illness, it is necessary to maintain constant contact with the ancestors. The following quotes illustrate some of the examples of the explanations given:

“As the patient continues with healing, he/she is regularly assessed through the divination bones to figure out the progress of his/her condition”. {Participant 5}

“As the patient is treated from home, his family will come to collect his medication.... Then I request them to take a thread that was soaked in the patient’s saliva and will be broughtt to me....Then I put it among my bones and ask the ancestors how his/her condition is”. {Participant 9}

“They can be given medicine to inhale every morning; they call it ‘mosutha’ and the patient is brought for consultation once after every three weeks for checkups”. {Participant 3}

“When they are at the indigenous healers’ place, patients are examined once a week to check their progress”. {Participant 2}

From the above statements, it can be concluded that the process of continuous assessment of the patients helps in evaluating the effectiveness of the treatment and progress in terms of prognosis of the symptoms. This process also serves to ensure the continuous healing process even when patients are being treated from their home environment. In this entire treatment process, the ancestors were found to play a significant role in promoting positive mental health outcomes.

4.3.7 Constant observation of patients during the treatment process

Most of the participants in this study preferred to admit the patients in their homestead even though for a short period, to stabilize and facilitate close monitoring and observation of the patients. The indigenous healers also give the patients some chores or activities to carry out which appears to be aimed at testing whether or not the patient was back to his/her senses. The following quotes illustrate the above points:

“To prove that he/she is recovering, he will ask for permission to visit home..... But I don’t allow them to leave alone. I go with him so that he shows me the way even though I know it. I just ask him to do so.....By doing so I will be observing if the mind is recovering or not..... And if he has not recovered, we see him by the lack of love for children because children like the company of sick people.....If he shouts at them, he is still sick but if he likes them, then recovery is taking place”. {Participant 6}

“When he starts conversing with us we listen to detect sense in the speech. To indicate that recovery is on the way the patient becomes shy when he looks at us then we know that he is able to remember what he/she did or said..... One can ask for bathing water and start demanding clean clothes”. {Participant 7}

“Again he is assessed by other means like taking him to the field and instructed to pluck off the maize plants..... If he refuses to pluck them off, it means he is improving, but if he continues it implies he is still ill..... The patient is tried several times with these different strategies until the indigenous healer is satisfied” {Participant 2}

One of the indigenous healer pointed out that there was a need for a follow up consultation with a patient four months after they are discharged. This arrangement provides the indigenous healer with the opportunity to assess the patient’s adjustive skills after being integrated back into the family and the community. The patient would also be given the opportunity in his/her life to make a rational choice of not continuing with the medication on his own unlike the time when people where taking decision for him/her. Here are some of the quotes in this regard:

“Yes. They will come back after four months so that we can observe how they are doing”. {Participant 10}

“We also give him muti to use at home until he stops on his own”. {Participant 9}

Although most of the indigenous healers admit patients for close observation, some opt to stabilize and then discharge the patient so that treatment can be continued at home under the care of family members. Below are some extracts to illustrate this:

“Then they will explain to the indigenous healer how he is coping, whether they see some improvement or whether the illness is still serious.....Sometimes they bring him along to check what the gods say about him”. {Participant 1}

“Yes, I treat all my patients from their own homes but some can be here for one week only until they become better before they go home because they will agree to drink the medication”. {Participant 3}

One of the key clinical tools that the indigenous healer uses is clinical observation. Such clinical observation is aimed at assessment of the following: a). the patient's behavioural functioning; b). social functioning; and, c). any disturbances in the patient's thought processes. Clinical observation is employed during the process of healing. This also serves as some form of guide to determine the level of recovery on the part of the patient.

Another interesting finding is that the indigenous healer encourages the family members to assist in the treatment process by observing the patient at home. In other words, the patient's interventions are also supplemented by the interventions that the patient's relatives are expected to make when the patient is at home.

"His relatives continually come to collect the medication.....Then they will explain to the indigenous healer how he is coping, whether they see some improvement or whether the illness is still serious". {Participant1}

"The indigenous healer gets a chance of finding out how the patient is doing.....I mean that they will explain whether the patient is saying sensible things or not and explain his general behaviour since he last took the medication". {Participant 3}

"The patient's relatives will frequent the place to collect medication and to report on his progress". {Participant}

It can be deduced here that although the patient was regarded as stable to be able to take treatment on his/her own, the family plays a very important role during the healing process. The indigenous healers are able to rely on the assistance of the patient's family when the treatment is continued at home. This is understood to ensure treatment compliance on the part of the patient. The family's involvement was also important for observing the progress of the illness and symptoms and then report back to the

indigenous healer. It can be deduced that the family contribution in the healing process serve as a valuable asset for support.

4.3.8 Treatment procedures that are executed on discharge of the patient

Almost all the indigenous healers reported that they will only discharge the patient when they are satisfied with progress. The decision to discharge the patient is also taken in consultation with the ancestors who will be guiding the indigenous healer throughout the process. Before being discharged, some medicines are administered to protect and strengthen the patient. In some cases, the patient would be given some herbs to continue using at home until he/she decides to stop. The following quotations from the interviews illustrate this:

“At that time we strengthen his body by injecting muti in his body so that the illness must never come back. Then he is healed and he goes home and slaughters a goat to propitiate the gods” {Participant 6}

“The patient will be summoned to come and get more medication to strengthen his body after being healed”. {Participant 3}

“Women can sweep or cook and if I am satisfied with their performance, the patient is healed and I release them home.....Aha! Then we throw the bones and learn what the gods are saying..... If they say he has recovered, we use a razor blade to inject medication in the self-made wound to strengthen his body so that the illness should not come back”. {Participant 7}

“When he is recovered they will bring him along for me to throw the bones and ask the ancestors if they are also satisfied.....Then we use other muti to strengthen his body.....We also give him muti to use at home until he stops on his own”.{Participant 9}

From the above extract, it was evident that the indigenous healers consider their interventions to be both curative and preventative. The herbs that are administered are considered to be effective in managing the condition of the patient. The herbs together with the rituals that are performed in constant liaison with the ancestors are considered to assist the indigenous healer to bring about positive change on the part of the patient. The family of the patient is also considered to be very important in the treatment and prevention programmes.

4.4 Summary of findings

The present study found that participants (the indigenous healers) seem to hold varying perceptions and beliefs regarding the conceptualization of mental illness, the causes as well as the treatment practices. Their perceived definition, causes and treatment appear to be culturally bound. It appears that the indigenous healers conceptualize mental illness as a condition that is manifested through a patient's loss of contact with reality.

It does appear also that indigenous healers consider a person who is mentally ill to be someone with significant levels of disorientation in terms of time, place and person. Mental illness was understood by the indigenous healers to be a result of multiple causes that include disconnectedness with the spiritual world, witchcraft, psychological factors, biological factors and substance abuse. The indigenous healers further pointed out that they have the capacity to diagnose the underlying cause(s) of mental illness based on the symptoms that the patient presents with.

Most of the indigenous healers in this study use divination bones (*ditaola*) during the assessment process to establish the nature of the problem that has brought the patient for consultation. It can be suggested that *ditaola* serves a critical diagnostic role in the management of mental illness. These diagnostic instruments also help the indigenous healer to determine the appropriate treatment that should be considered for the patient with mental illness. According to the indigenous healers, the diagnostic power of the divination bones is enhanced by the intervention of the ancestors. Apart from using the divination *bones* as part of the diagnostic process, some of the indigenous healers

indicated they are able to determine the nature of the illness by directly focusing on the symptoms.

Ninety percent (90%) of the indigenous healers who participated in this study prefer to admit the patients in their homestead during the period of treatment. They indicated that the healing process of mental illness is long and therefore patients are admitted for a period of a week to six months depending on the progress of the illness. This was done to enhance monitoring and observation of the patient closely and stabilizing of unstable patients. It was found that there are two major modalities that the indigenous healers follow in the treatment of patients presenting with mental illness. These treatment modalities are: the use of herbs and the performance of rituals.

It was also found that indigenous healers can exercise their right to refuse administering treatment to individuals who pose a threat to others because of their evil intentions or deeds. In cases where the indigenous healer feels that he/she is not adequately skilled, there is provision to refer patients to colleagues or to the hospital. This suggests that indigenous healers are amenable to working collaboratively with their colleagues or with Western trained health care practitioners.

The findings from the study suggest that the more psychotic or violent patients are approached differently when compared to other patients. The indigenous healers appear to have the capacity to differentiate the presenting symptoms of psychotic patients from non-psychotic patients, hence the different approaches that are adopted when treating more psychotic and non-psychotic patients. It can therefore be deduced that indigenous healers are able to identify psychotic or violent patients and to implement appropriate intervention strategies to stabilize them. It can therefore be argued that indigenous healers perceive themselves as having the necessary skills and expertise to handle unstable patients and to create a conducive environment that promotes treatment. This suggests that indigenous healers have some specialized knowledge on how they classify and prioritize their patients, based on the clinical picture that the patient presents with.

While the process of healing continues, the indigenous healer continues to receive guidance from the ancestors on how best to treat the patient. The healers emphasized that due to the prolonged treatment period for mental illness, it is necessary to maintain constant contact with the ancestors. It can be concluded that the process of continuous assessment of the patients helps in evaluating the effectiveness of the treatment and progress in terms of prognosis of the symptoms. This process also serves to ensure the continuous healing process even when patients are being treated from their home environment. In this entire treatment process, the ancestors were found to play a significant role in promoting positive mental health outcomes.

Although most of the indigenous healers admit patients for close observation, some opt to stabilize and then discharge the patient so that treatment can be continued at home under the care of family members. One of the key clinical tools that the indigenous healer uses is clinical observation. Such clinical observation is aimed at assessment of the following: the patient's behavioural functioning, social functioning and any disturbances in the patient's thought processes. Clinical observation is employed during the process of healing.

This also serves as some form of guide to determine the level of recovery on the part of the patient. It can be deduced that although the patient was regarded as stable to be able to take treatment on his/her own, the family plays a very important role during the healing process. The indigenous healers are able to rely in their assistance during treatment procedures at home to ensure that there is treatment compliance. The family's involvement was also important for observing the progress of the illness and symptoms and then report back to the indigenous healer.

It can be deduced that the family contribution in the healing process serves as a valuable asset for support. Almost all the indigenous healers reported that they will only discharge a patient when they are satisfied with progress. The decision to discharge a patient was also taken in consultation with the ancestors who will be guiding the

indigenous healer throughout the process. Before being discharged, some medicines are administered to protect and strengthen the patient. The indigenous healers consider their interventions to be both curative and preventative. The herbs that are administered are considered to be effective in managing the condition of the patient.

CHAPTER 5: DISCUSSION OF FINDINGS

5.1 Introduction

The purpose of the study was to explore the treatment of mental illness by indigenous healers in Moletjie. This chapter presents and discusses the findings of the study in relation to the information gathered and the literature reviewed. These findings will be discussed according to the emerging themes identified in the previous chapter.

5.2 Emerging themes

5.2.1 Indigenous healers' notions of mental illness

It emerged from the present study that the indigenous healers define mental illness differently. Although the indigenous healers did not have a common definition, they tended to mainly conceptualize mental illness as a condition that is manifested through a patient's loss of contact with reality. These kinds of explanations are consistent with the study conducted by Ae-ngibise, Cooper, Adibokah, Akpalu, Lund, Doku & The Mental Health and Poverty Project (MHaPP) Research Programme Consortium (2010), who found that in Ghana, indigenous and faith healers' understanding of mental illness is consistent with the cultural explanatory models of mental disease etiology.

The findings further lend support to the assertion by Mufamadi (2001) who suggested that there seems to be no clear definition of what is regarded as mental illness. In a study by Teferra and Shibre (2012) focusing on perceived causes of severe mental disturbance and preferred interventions by the Borana semi-nomadic population in Southern Ethiopia, it was also found that participants tended to associate mental illness with a psychotic condition known as *marata* (the Borana Oromo word for 'mad' which is slightly derogatory). Based on the aforementioned, it can be argued that indigenous healers tend to understand mental illness as a relatively severe condition that is characterized by a patient's loss of contact with reality.

5.2.2 Perceived causes and symptoms of mental illness

The participants in the present study perceived mental illness to be caused by a number of factors that include: social, biological, psychological and spiritual factors. The spiritual factors associated with mental illness are spirit possession and when a patient cuts ties with the ancestors or in cases where a patient fails to heed the ancestors' call. Conditions such as epilepsy, inherited illnesses and untreated childhood diseases were perceived to be caused by biological factors. The mental illnesses associated with the social dimension included substance abuse disorders and witchcraft.

Psychological factors associated with mental illness were found to include stress and social stressors. Interestingly, the symptoms were also grouped according to the participant's belief of the causative factor. For example, patients presenting with social withdrawal, tearfulness and thinking a lot were associated with stress, whereas aggression and violent behaviour were perceived to be caused by substance abuse.

Similarly, in the study by Teferra and Shibre (2012), themes referring to causes of severe mental disturbance were categorized. For example, bewitchment, spirit possession and curse were grouped in one core category 'supernatural', while other themes such as infections, substance abuse and loss were grouped under a core category 'biological and psychosocial'. This notion was supported by a study conducted by Sodi (1998) where he maintained that traditional healers classified and labelled clusters of symptoms that are a source of distress to their patients. They defined their syndromes by severe similarities of behavioural disturbances. The same results applied in the study conducted by Ventevogel et al. (2013), wherein the respondents listed a wide range of possible causes for disorders with severe behavioural disturbances including spiritual, natural and psychosocial factors.

The predominant views held in this study population regarding causes of mental illness incorporated bewitchment and witchcraft to be the causes of mental disturbance. The participants indicated that witchcraft comes in different forms for example, being bewitched by people because of the element of jealousy and in others it was the result

of retaliation after someone had stolen, murdered or bewitched others. Participants perceived symptoms like presenting with unusual behaviour, restlessness, violent behaviour, physically restrained with ropes or chains and speaking uncontrollably as being associated with witchcraft.

These results correlate with the results of the study by Teferra and Shibre (2012). They discovered that the concept of bewitchment was particularly related to the evil deeds of others. If someone takes (steals) someone else's money or material, the person who lost the money or material may do something in retaliation, which will make the other person go mad. People would say the individual concerned became mad because he/she took someone else's property. From an African perspective, the ill-will or ill-action of one person against another causes the sickness, disease and misfortune, normally through the agency of witchcraft and magic (Mbiti, 1969). The results of the current study concur with those from the study conducted by Mufamadi and Sodi (2010), and Sorsdahl et al., (2010) which found that heredity, witchcraft, sorcery, disregard of cultural norms and spirit possession were regarded by the indigenous healers involved as some of the causes of mental illness. In the present study patients who presented with hallucinations, sleep disturbance, disruptive behaviour were perceived to be caused by substance abuse (*dagga and nyaope*). Aggression and violence were also perceived to be influenced by substance abuse.

Evidence in the present study suggests that spiritual dimension (i.e. illness as a result of cutting ties with the ancestors and not heeding to their call) and evil spirit possession were regarded as other causes of mental illness. They perceived symptoms like walking aimlessly and loss of control of mind as an indication of mental illness. The indigenous healers in this study indicated that people who were called by ancestors to be initiated as indigenous healers may also present with symptoms of mental illness like roaming around, disorganized behaviour, bizarre behaviour and sometimes, aggression.

Similar results were found in the study by Mufamadi & Sodi (1999) that the chosen indigenous healers are widely known to display signs such as aggression, social withdrawal, or bizarre behaviours until such time they accept the calling and undergo training. This concurs with the results of the study by Karim, Ziqubu-Page and Arendse (1994) who found that symptomatically, the chosen individual becomes ill or behaves like a mentally disturbed person. These findings were further supported by the study conducted by Bodibe (1992), who found that mental illness and physical afflictions were caused by failure by the living to follow the instructions of the ancestors. Furthermore, in the study conducted by Teuton, Dowrick and Bentall (2007), indigenous healers (in Uganda) indicated that the cause of these disorders was not specific to the person, but could be due to any family member or members neglecting cultural practices.

Similarly, a study exploring the belief system surrounding causes and symptoms of mental illness in a primary care setting in Saudi Arabia reported that patients attributed their symptoms to religious and supernatural factors, saying it could be the result of punishment from Allah (Alqahtani & Salmon 2008). For instance, a study done in Nigeria by Gurege, Lasebikan, Ephraim-Oluwanuga, Olley and Kola (2005), involving a large community survey, found that as many as one third of the respondents suggested that possession by evil spirits could be a cause of mental illness which is also consistent with the findings of this study. Some few participants reported the same belief that those who do not perform the required rituals create discordance in the spiritual realms, which may in turn cause mental disorder. Similar results were found in the study by Kale (1995) that ancestral spirits can make a person ill.

More frequently the participants in the current study reported that psychosocial factors such as stressful life events and stress were perceived to be associated with mental illness. The participants reported that those kind of patients present with symptoms like thinking too much, tearfulness, social withdrawal, and suicidal ideation. Chavunduka (1994) also found that indigenous healers often consider mental illness to result from psychological causes such as worry, strain and tension. Thinking too much was repeatedly mentioned by the participants of this study as predominantly the cause of

mental disturbance, which was consistent with the findings from Zimbabwe by Abas, Brodhead, Mbape and Khumalo-Sakatukwa (1994) and from Uganda by Okello & Ekblad (2006), which found a similar attribution style referring to less severe forms of mental distress such as the non-psychotic conditions referred to as “worry”.

Interestingly, the participants of the current study reported biological factors like inherited illness, untreated childhood illnesses (*lekona*), repeated convulsions in epilepsy and food poisoning as more prominent causes of mental illness. Such patients were perceived to present with symptoms like pressure of speech, confusion, unstable behaviour and restlessness. Similarly, mental illnesses were reported to be heritable by a small number of the participants in the study by Teferra and Shibre (2012). Most of the symptoms presented in the current study are similar to those presented by other studies in other countries and ethnic groups, but the difference could be the perceived causes and these perceptions appear to be culturally defined.

5.2.3 The process of assessment using the divination bones (*ditaola*)

The present study found that indigenous healers mainly use divination bones (*ditaola*) that serve as a critical diagnostic tool in the management of mental illness. It has also found that although divination bones (*ditaola*) are commonly used by the majority of healers, there are also those who indicated that they observe the patient’s physical appearance or the presenting symptoms in order to determine the diagnosis. These findings lend support to Kruger’s 1978 study which found that diagnostic procedures might vary from one indigenous healer to the other depending on a number of factors like the healer’s preferences and the nature of the training he/she has received.

The indigenous healers in the current study reportedly perceive the throwing of the divination bones (*ditaola*) to be equated to a stethoscope used by the Western practitioners for diagnosing, and these results lend support from previous studies wherein the divination bones (*ditaola*) were used as a diagnostic tool, studies such as those conducted by Makgopa and Koma (2009); Kiev, (1989); Peltzer, (1989); (1995); Sodi, (1998) and (2009).

The indigenous healers indicated that diagnosis is guided by the ancestors and an attempt to identify and diagnose the particular phenomenon experienced by the patient must link the patient's idiosyncratic experience with a culturally meaningful understanding. Similar findings were found in the study conducted by Ae-ngibise et al. (2010) in which the indigenous healers indicated that there is a need to consult the ancestors with every patient that comes for treatment in order to receive spiritual guidance in terms of appropriate diagnosis and treatment.

These findings lend support to the study by Makgopa and Koma (2009) which found that the throwing of divination bones by an indigenous healer as well as the interpretation of the bones reveals the power and the presence of ancestral spirits. In the current study, the indigenous healers have shown that during the diagnostic process, the divination bones (*ditaola*) are referred to by their figurative names which an ordinary person cannot understand. The indigenous healer will interpret them and make sense and meaning of what was told by ancestors and then convey the message to the patient.

In a study conducted by Mufamadi (2001), it was found that the indigenous healers communicate these diagnostic labels in a language that is understandable and consistent with the patient's cultural world view. Through the divination bones (*ditaola*), the indigenous healer has the ability to give culturally appropriate explanations about the causes of a client's distress. The recognition of mental disorder also depends on a careful evaluation of the norms, beliefs and customs within the individual's cultural environment (Kabir et al., 2004). People's beliefs regarding mental illness is not only to be known, but the purpose of their beliefs should be understood.

According to Makgopa and Koma (2009), the bones are not randomly picked, but are carefully selected based on prior understanding and knowledge of the life styles of the animals from which the divination bones are extracted. The sources consist of different domestic and wild animals. They can be said to be special because these bones are used for diagnosing and healing of diseases. The indigenous healers in the current

study indicated that the family and the patient have to settle down first after rapport has been established, so that the message from the ancestors can be conveyed to them in the language they understand. This was also confirmed by the results of the study conducted by Makgopa and Koma (2009) that the indigenous healers are responsible for explaining the meaning conveyed by the divination bones to people under their care.

In the current study, one of the participants indicated that patients were not supposed to tell the indigenous healer what he/she was suffering from. Instead, the indigenous healer will inform them about the problem and its cause in the process of the assessment. This concurs with the findings of the study conducted by Juma (2011) who pointed out that, contrary to the Western approach to healing where the client tells the healer/therapist why he/she has come, in the African healing tradition it is the indigenous healer who reveals the patient's problem, including the steps to be taken to restore good health to the patient. Similarly, Chavunduka (1994) found that some healers are able to inform their patients of the reason for their visit and the social cause of their illness without having been told anything by the patient.

5.2.4 General treatment practices

The current study found that ninety percent (90%) of the indigenous healers prefer to admit patients in their homestead even if it was for a short period. The study further reports that patients were admitted during the treatment process and that this could vary in duration, for example, from a short period to approximately six months. The participants believed that keeping patients closer will enhance proper treatment as the healing process is long by its nature. For instance, they will be able to evaluate the progress, encourage treatment compliance and observe any changes on the patient like deterioration or improvement of the condition.

The study has also shown that other indigenous healers indicated that they believe that patients should be treated at a different place than home to reduce the severity of the illness. Some patients were stabilized for a period of a week and then treated at home under the care of their family as it is believed that these will comply with the treatment

during that period. This concurs with the findings of the previous study by Sorketti and Habil (2009) which found that indigenous healers in Sudan kept their patients in their homes for the duration of 40 days to 6 months or more depending on the prognosis of symptoms and condition. The findings further lend support from the results of a study by Ngoma, Prince and Mann (2003) in Tanzania, where indigenous healers kept their mentally ill patients in their homes.

The current study has shown that there are two major treatment modalities that the indigenous healers use which are herbs and the performance of rituals. Treatment procedures could be perceived as mainly directed at the individual patient so as to restore his/her level of contact with reality. It was also found that indigenous healers can exercise their right to refuse administering treatment to individuals who pose a threat to others through their evil intentions or deeds.

The current study has found that indigenous healers used common intervention strategies of administering herbs including: steaming, taking herbs nasally and orally, bathing, smoke inhalation, speaking towards the herbs, whipping, cleansing, sometimes not bathing for some days with the belief that the herbs are still in the process of healing and should not be removed. The indigenous healers in the present study used among others the herb called "*mošimanyana wa nageng*" to sniff (like snuff) so that the person must sneeze to take out the disease. The findings of the current study have revealed that the indigenous healers make a small incision on the body with a blade or porcupine thorn and apply herbs on the bleeding area as another method for treatment. The results also show that most of the indigenous healers make use of a team of people to assist during treatment procedures like restraining when the patient becomes violent or during steaming and smoke inhalation.

These results lend support to previous studies (see Hadebe, 1986; Mahwasane, Middleton & Boaduo, 2013; Gumede, 1990) which found that some intervention strategies may include enema, steaming, taking medicine nasally and vaccinations. Peltzer (1989) confirms the use of herbal extracts mixed with other liquids, which healers administer directly into the blood stream by making bodily incisions.

Another important finding emanating from the present study is the performance of rituals as another form of treatment for mental illness. These rituals are performed either to mend a broken relationship with the ancestors or to welcome home the discharged patient. These rituals and celebrations of healing may involve slaughtering of animals to appease the ancestors. As a symbol of the strengthened relationship, the patient will be expected to wear “*sethokgolo*” (a small piece of the skin of the slaughtered animal) as a wristband. The present study further found that to be initiated as an indigenous healer was another form of treatment for mental illness. When the person agrees to respond to the ancestral call, some rituals would then be performed upon completion of the initiation process to celebrate the acceptance.

The findings from this study are consistent with those of earlier studies by Sodi (1998; 2009), which have shown that the actual healing transactions consist of a series of medical and psychological procedures which include, among others, the use of herbs and performance of culturally appropriate rituals. These results also concur with those of the studies conducted by Mpofo (2006) and Chavunduka (1994) which revealed that ritual enactment is one approach that indigenous healers use to cast away malevolent spirits.

Indigenous healers in the present study were found to rely on some significant signs that show them a patient’s recovery. These include sweating, vomiting, sleeping, sneezing and feeling weak. The same results were found in a study by Mufamadi (2011) who also pointed out that sweating, vomiting, sneezing and releasing mucus are seen to have some therapeutic value since these are regarded as signs that the illness is leaving the body.

It was also discovered in this study that the beliefs about the causes of mental illness influence the choice of treatment and methods. One indigenous healer in the present study talked about the symbolism associated with his treatment methods. For example, in the case of one patient who was roaming around and disappearing from home, the indigenous healer would collect soil from his foot print, mix this with a herb (*molebatša*) and the skin of a python. This was further wrapped together in the form of a wreath made out of a thorny herb (*tshehlo*) and was put at the patient's home so as to stop him from disappearing from home. According to the indigenous healers in the current study, the python skin was used because they believed that when the python had a full stomach it does not move away but stays in one place until the stomach is empty. Therefore, the patient would simulate that and would not go away from home. This narration by the indigenous healer seems to lend support to the findings by Mufamadi (2001) who had earlier indicated that indigenous healers believe they have medicines that can make a person to stay in one place.

Additionally, the name of the herb (*molebatša*) means "to forget". With this one, the indigenous healers believed that using the herb would make the patient to forget what he used to do, say or think. It was also found in this study that a patient's recovery can be enhanced or accelerated by making wrist bracelets with the skin of an elephant. This seems to lend support to the results of the study by Staugard (1985) in Botswana, who found that other methods of treatment used by indigenous healers include the use of amulets, bracelets, charms and necklaces. Similarly, in the study by Mpofu (2003), the treatment methods used by indigenous healers were classified as follows: a) physical activity with management of interpersonal relationships; b) use of expectation; c) use of symbolism and enactment; d) use of naming; e) dream interpretation, and f) cleansing, libation and scarification. In the current study, the patients were cleansed in a flowing river with the belief that the disease would flow away with the river and leave the patient.

The findings of the current study show that there are typical treatments which reflect the beliefs and perceptions of people being treated and that of the indigenous healer, as was evidenced on the person who was believed to be bewitched because of his good performance at school. As part of the treatment of such a person, the page of a used book (where the patient wrote) was mixed with the herb called "*maimé*", together with a piece of music record and these were burned. Then the person had to undergo smoke inhalation treatment for several days until he was declared cured. The findings further lend support from the views of Leventhal and Nerenz (1985) who stated that culture is a strong determinant of people's perceptions of illness, its perceived causes and treatment options as compared to other personal attributes.

In the present study, what was perceived to be the cause of the illness, in a way, determined the treatment modality to be executed. Looking at the above notions of health and illness, it is evident that efforts aimed at restoring health to individuals who are ill are shaped by the cultural and social realities of a particular culture and customs. The findings from this study revealed that some indigenous healers acknowledged the indigenous healing system's limitation on other mental illnesses such as inherited illnesses and those caused by untreated childhood illnesses like *lekona* and epilepsy. They further indicated that in other instances they do refer their patients to the bio-medical facility where treatment by Western medication is generally thought to be effective in their management of such cases.

These findings are in line with what Case, Menendez and Ardington (2005) deduced, that the services provided by indigenous healers appear to be complementary to, rather than substitutes for, those provided by public and private doctors. Indigenous healers also indicated that they prefer to work collaboratively with other colleagues. They share information and herbs and also refer patients to each other, which were also indicated in the study by Karim et al. (1994) that African healers usually work co-operatively and not competitively with one another. As demonstrated by the indigenous healers interviewed in this research, the participants mostly preferred to treat patients or use herbs at dawn and late afternoon, which are treatment models that reflect their own values. This

supports what Mpofu (2006) discusses, that healing from African worldviews is knowledge and practices used in the diagnosis, prevention and elimination of physical, mental and social imbalance.

5.2.5 Treatment approaches for psychotic patients

Although indigenous healing is perceived as opposed to the clinical procedures and logical thought sequences of Western medicine, the indigenous healers in this study were able to identify psychotic patients with varying symptoms that they presented with and were able to employ immediate treatment interventions necessary to stabilize them. The indigenous healers in this study appear to display their knowledge in patient stabilization. This strategy by the indigenous healers is in line with the Western perspective of stabilizing psychotic patient first as a first goal of treatment. The indigenous healers in the current study indicate that the healers possess the skill in the prioritization of patients under their care, namely those presenting with perceived psychosis like disorganized behaviour, disorganized speech, hallucinations, changed emotions and confused thinking. Psychosis was mostly attributed to witchcraft and substance abuse.

The current study found that psychotic patients were managed effectively with traditional methods of treatment. The treatment involved striking the patient with a stick smeared with herbs and at times administering some herbs that can induce vomiting. These treatment methods tended to calm the patient and to get him/her to fall asleep, thus minimizing the psychotic manifestations of the mental illness. Similarly, Abbo (2011) found that indigenous healers treat psychosis with various methods that include herbs, appeasing the spirits and divination.

5.2.6 Continuous assessment during the treatment process

The findings of the present study indicated that assessment was not only done on admission or discharge of the patient, but was a continuous process. The assessment was found to be used to evaluate the prognosis of the patient's condition, effectiveness of the treatment and to encourage continuity of treatment by the patient. This

continuous assessment was believed to assist ancestors to convey messages about the patients through the indigenous healer. For example, through this process of continuous assessment, the indigenous healer is able to know about when to change the herbs and the type of procedures that need to be carried out.

5.2.7 Constant observation of patients during the treatment process

The study found that indigenous healers used a number of strategies aimed at testing whether or not the patient was in touch with reality. For example, a patient would be asked to lead the indigenous healer to his/her home. Such activities are regarded as important as they generally help the indigenous healer to assess effectiveness of the treatment. In an earlier study, Mufamadi (2001) also found that the successful completion of domestic tasks was widely used by the indigenous healers to assess a patients' progress. Similarly, in this study, patients were observed with domestic tasks like cooking and sweeping the environment.

The indigenous healer would also listen to the conversation of the patient with others to establish whether or not the patient is improving. In other instances, patients were observed when they engaged in other domestic chores like herding of cows and working in the maize field. Another interesting finding in this study is the important role that family members play when patients are sent home. They also observe the patient's interaction with them and how he/she engages with the domestic chores and report back to the indigenous healer about the progress.

It was also found that some of the discharged patients are brought back to the indigenous healer with the aim of assessing the patient's adjustive skills after being integrated back into the family and the community. A study by Sodi (2009) also found that indigenous healers tend to apply some strategies that are aimed at testing whether or not the patient is back to his senses. For example, a patient's reluctance to use a leaking container to fetch water will be interpreted as one of the hopeful signs that the illness is remitting. It was also discovered that apart from establishing a patient's level of

contact with reality, these procedures appear to facilitate interpersonal contact and to broaden the patient's social network.

5.2.8 Treatment procedures that are executed on discharge of the patient

The present study found that indigenous healers consult with the ancestors first through the process of assessment before discharging a patient. The results of this study also found that patients that were treated from their homes are brought back to the indigenous healer's homestead to be assessed again by divination bones and find out if they are completely healed. Thereafter, the patients are treated for the final procedures like incising the wound and putting the herbs on the bleeding wound, cleansing, performance of ritual ceremonies at home so as to protect and strengthen the body or even preventing recurrence of the illness and any potential illnesses. Similar results were found in the study conducted by Chavunduka (1994) and Sodi (1998) wherein the medicine was rubbed on the incised wound to strengthen the body. Treatment may be focused on the quality healers provide to their patients with the aim of preventing them from contracting the same illness again.

These findings supported results of previous studies by Corin and Bibeau(1980), Nzewi(1989b); (cited in Sodi, 1998) who indicated that treatments may be directly curative or may include protective or preventive factors. It was further shown that on discharge of the patient, treatment methods used include incision on the head (fontanelle) with the belief that should the patient bleed, then the patient will never contract the same illness again. Consistent with these findings, bloodletting was also found to be the other treatment technique used to cast out the illness in the study conducted by Karim et al. (1994).

Similarly, Sodi in his study of (2009) found that before a patients are discharged to their homestead, they will be treated with some protective medicines that are believed to ward off potential threats. This also was supported by Makgopa (2004) who suggested that: "Traditional treatment uses a comprehensive approach, which is holistic by nature,

curative, protective, preventive and finally it can be natural or ritual, sometimes a combination of both” (p. 137).

CHAPTER 6: SUMMARY AND CONCLUSION

6.1 Summary

This qualitative study explored treatment of mental illness by indigenous healers in Moletjie, Capricorn District, Limpopo Province. Indigenous healers participated in this study were given the opportunity to share their knowledge on how they treat mental illness. Although, they all treat mental illness, they appear to hold varying perceptions and beliefs with regard to the definition of the concept. Culture appears to contribute on what was perceived to be the causes and treatment thereof. These various perceptions are localized and, therefore, show the influence of contextual factors in shaping what illness is and their experiences. Some of the causes of these mental illnesses in this study were accounted for by African traditional beliefs like spiritual dimension and witchcraft, while others could be explained from Western perspectives like thinking a lot, hereditary illnesses and epilepsy.

The results demonstrated that the belief systems and practices of Africans play a crucial role in defining and treating mental problems. It was evidenced in this study that there are two treatment modalities employed, which are the use of herbs and ritual performance. Furthermore, the study has revealed that the indigenous healers who participated in this study make use of the divination bones (*ditaola*) as the assessment tool for diagnostic purposes being guided by the ancestors. The results has also shown that the majority of the participants had more pragmatic approach of trying all in their capacity to help those in their care to the extent of admitting them, prioritize them and stabilize the unstable patients. The present study found that during the healing process, prognosis of the illness is being observed for the patient's thought processes, social and behavioural functioning.

The results also have shown that indigenous healing of mental illness includes curative, protective and preventive factors. Another important aspect discovered by the study was the role played by family members during the treatment process. The findings also revealed that indigenous healers in this study work collaboratively with each other and

also with the biomedical facility. The study illustrates that the management of patients on discharge was both curative and preventative.

Based on the results of the present study, it can be deduced that indigenous healers' approaches to the treatment of mental illness are valuable if utilized in their relevant cultural contexts. It can also be argued that the indigenous healers' view of disease is more in line with the African patient's beliefs. In Africa, indigenous healers are generally perceived to be more accessible than biomedical practitioners; and also that patients prefer to express themselves clearer and have confidence that they are understood on what they attribute their illness to. African indigenous healing clearly reflects a holistic approach to understanding and explaining health, and illness is seen to be the first priority Africans have in seeking solutions to health.

This research suggests that patients with common mental disorders constitute a large part of the population consulting the indigenous healers and therefore provide a learning curve to other stakeholders like the Western trained health care providers. These findings could assist them to have an understanding that from an African perspective, restoration of health, whether mental or physical, lies within the social and cultural contexts. This avenue can further be extended to the authorities, namely the policy makers in the Department of Health in the development of culturally-sensitive health care intervention strategies. Finally, the researcher in this study concludes by asserting that all the objectives of the study have been met and also that the findings of the study are supportive of other research findings and theoretical perspectives.

6.2 Limitations of the study

The researcher is aware of the considerable limitations of this study. Firstly, the study was conducted in only a few rural villages of Moletjie. The current findings may therefore not be generalizable beyond the places where the study was conducted. The study dealt with the issues of one culture only, the Pedi culture. Therefore, the current data are limited, and cannot shed light on how the illness categories in the lives of Africans in other cultures in South Africa and elsewhere would play out.

Secondly, the present study only focused on the indigenous healers' accounts of their treatment approaches. Patients who were treated for mental illness and family members that were part of the healing process were not interviewed. Consequently, the present study gave a one-sided interpretation of the approaches to treatment of mental illness.

Thirdly, other indigenous healers pointed out that they did not want to divulge such information as they considered their diagnostic knowledge and herbs to be inherently secretive, and were only to be shared with their close families or initiates and colleagues. The indigenous healers seemed to be very suspicious as some of them felt that some people wanted to steal their knowledge. As a result, it is possible that some indigenous healers may have opted not to reveal all their knowledge regarding the treatment of mental illness.

Fourthly, the researcher acknowledges that pretesting was not conducted and is one of the limitation of the study. Lastly, the researcher acknowledges the limitations associated with translation of information from one language to another. It is thus possible that the translation of the interview data from Sepedi into English before a phenomenological explication was done may have led to omissions or inappropriate substitutions of the original material provided by the participants.

6.3 The significance of the study

The findings of the present study suggest that a large proportion of people receive treatment and care of their mental health problems from the indigenous healing system, and not only from Western health facilities. This shows the evidence that indigenous healing still plays a role as one of the forms of health care in South African society. It is evident from the present study that some communities still perceive the indigenous healer as accessible and affordable. It will seem that some community members may not seek mental health treatment in the formal health sector as this option is perceived as not readily available and inconsistent with their cultural experiences. The indigenous healing system seems to be used by community members to avoid miscommunication

and misunderstandings based on language and cultural differences with the Western trained practitioners. The results have nonetheless provided valuable information in reflecting on the role played by African traditional beliefs and practices in understanding psychological problems.

One of the conclusions of this study is that participants indicated that a patient's presenting problems reflected their African traditional beliefs, the meaning they attach to the illness and perceived causes of their illness. From these beliefs and perceptions, participants understood that those in their care defined their conditions in the context of biological factors, psychological conflicts or disturbed social relations and spiritual dimensions that created a discomfort expressed in the form of physical or mental problems. Against this background, culture may be viewed as some form of a lens by which people experience, make sense of and react to their illness (Shai, 2012).

It is hoped that the findings of this study will help in transcultural understanding of mental illness. The results will also contribute to the wealth of knowledge in African psychology. Lastly, the findings will help Western trained health practitioners and other stakeholders to better understand indigenous healing systems as an alternative method in the treatment of mental illness. Therefore acknowledgement of this healing system and its usage by other stakeholders would be in the best interest of the people.

6. 4 Recommendations

Based on the above findings, the following recommendations are made:

- Some of the indigenous healers who participated in the study indicated that the system of being a member of the association has made it easier for them to share information with other people like the researcher because initially they were taught not to share information with anyone as this was regarded a family matter that goes from generation to generation. With this kind of comments the researcher understands this to be a rare opportunity for learning from each other i.e., is to encourage collaboration between Western-trained doctors and

indigenous healers, and to increase communication between these two sectors through meetings, workshops and seminars.

- A call for higher education institutions to incorporate culture, more especially in health education and training programmes might be beneficial to the multicultural society of South Africa.
- Some of the themes that were arrived at could have called for a more in-depth study. For example, the ongoing assessment by divination bones during the healing process of the patient may require further investigation by future studies.
- The researcher advocates that treatment of mental disorders should be made a priority for the health care system as this will assist individuals and communities in identifying and treating such diseases early and in a more effective way.

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ANNEXURES

ANNEXURE 1(a): SEMI-STRUCTURED INTERVIEW GUIDE

INTERVIEW GUIDE

1. May you kindly share with me your understanding of what mental illness is?
2. In your view, what do you consider to be the causes of mental illness?
3. Kindly describe to me in detail how you treat mental illness.

ANNEXURE 1(b): SEMI-STRUCTURED INTERVIEW GUIDE (SEPEDI)

INTERVIEW GUIDE

1. Naa le ka nhlalosetsa gore le kwešiša bolwetši bja monagano e le eng?
2. Go ya ka lena, le bona okare bolwetši bja monagano bo hlolwa ke eng?
3. Nhlalosetseng ka botlalo ka mokgwa wo bolwetši bja monagano bo alafiwago ka gona.

ANNEXURE 2 (a): PARTICIPANT CONSENT LETTER AND FORM

Department of Psychology
University of Limpopo (Turf loop Campus)
Private Bag X1106
Sovenga
0727
Date_____

Dear Participant

Thank you for showing interest in this study that focuses on exploration on the treatment of mental disorders by indigenous healers in Moletji, Limpopo Province.

Your responses to this interview will remain strictly confidential. The researcher will not identify you with the responses you gave during the interview or disclose your name as a participant in the study. Please be advised that your participation in this study is voluntary and that you have the right to terminate your participation at any time.

Kindly answer all the questions as truthfully as possible. Your participation in this research is very important. Thank you for your time.

Yours Sincerely

Phuti Mashamaite
Masters Student

Date

Prof. T. Sodi

Date

ANNEXURE 2 (b): PARTICIPANT CONSENT LETTER AND FORM (SEPEDI)

Department of Psychology
University of Limpopo (Turf loop Campus)
Private Bag X1106
Sovenga
0727
Date _____

Motšeakarolo

Ke leboga go bontšha kgahlego ga lena go lesolo le la go nyakišiša ka mokgwa wo dingaka tsa setso di alafago malwetsi a monagano ka gona ko lefelong la Moletjie, Limpopo Province. Maikemišetšo a lesolo le ke go kwišiša ditsela tseo ba alafago bolwetši bja monagano ka gona.

Dikarabo tša lena go diputšišo tše di tla tshwarwa ka mokgwa wa sephiri. Monyakišiši o tla leka ka mešegofela gore a seke a le amanya le dikarabo tše le tla di fago, le ge ele go se utulle leina la lena bjalo ka motšeakarolo lesolong le. Le tsebišwa gore go tšea karolo ga lena go lesolo le go dirwa ka boithaopo, le gore lena tokelo ya go ikogela morago nako efe go ba efe.

Le kgopelwa go araba diputšišo tše ka botshephegi bjo bo golo. Go tšea karolo galena go lesolo le go bohlokwa kudu. Ke leboga nako ya lena.

Wa lena

Phuti Mashamaite
Masters Student

Prof. T. Sodi
Supervisor

Letšatšikgwedi

Letšatšikgwedi

ANNEXURE 3 (a): CONSENT FORM TO BE SIGNED BY PARTICIPANT

CONSENT FORM

I.....hereby agree to participate in a Master's research project that focuses on exploring how indigenous healers treat mental illness in Moletji, Limpopo Province.

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

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

Signature:

Date:

ANNEXURE 3 (b): CONSENT FORM TO BE SIGNED BY PARTICIPANT (SEPEDI)

Foromo ya tumelelo

Nna _____ ke dumela go tšea karolo go lesolo la go nyakišiša ka mokgwa wo dingaka tsa setso di alafago bolwetši bja monagano ka gona ko lefelong la Moletjie, Limpopo Province.

Ke hlaloseditšwe ka maikemišetšo a lesolo le, ebile ke kwešiša gore ke tšea karolo ka go ithaopa gape ntle le go gapeletšwa. Ke kwešiša gore nka ikgogela morago go tšea karolo lesolong le nako efe le efe ge nka Kwa kesa nyake go tšwela pele, le gore kgato yeo e ka se nkame ga mpe.

Ke kwišiša gore maikemišetšo a lesolo le ga se go nthuša ka bonna, le gore leina la ka le ge e ka ba ditaba tše di filwego ka nna di ka se utullwe (di tla šireletšwa).

Signature: _____

Letšatšikgwedi: _____

APPENDIX 4 (a): PERMISSION TO CONDUCT RESEARCH

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

The President
African Religion/ Culture & Health Forum
P.O.Box 656
MANYAMA 0753
POLOKWANE
0700

Re: Permission to conduct research from indigenous healers.

I am a registered student in the above-mentioned institution. As part of the requirement for the Master's degree in Psychology, I am doing a research project. The title of the research project is: **An exploration of the Treatment of Mental Illness by the Indigenous Healers in Moletjie, Capricorn District, Limpopo Province.** The purpose of the study is to explore how indigenous healers treat mental illness.

I hereby apply to be granted permission to conduct this research among the indigenous healers that are members of the association. It is important to point out that the researcher undertakes to maintain confidentiality regarding the identity of the participants in this research project. The participants will be assured about the voluntary

nature of this study. Further, the participants are free to withdraw from the study at any time should they wish to do so.

The method of data collection will be semi-structured, one-to-one interviews with the indigenous healers belonging to the association.

Yours Sincerely

Ms Phuti Mashamaite
Masters Student

Date

Prof. Tholene Sodi
Supervisor

Date

APPENDIX 4 (b): PERMISSION TO CONDUCT RESEARCH IN SEPEDI

Department of Psychology
University of Limpopo (Turf loop Campus)
Private Bag X1106
0727, Sovenga
Date_____

The President
African Religion/ Culture & Health Forum
P.O.Box 656
MANYAMA 0753
POLOKWANE
0700

Re: Tumelelo ya go dira dinyakišišo go dingaka tša setšo.

Ke moithuti Unibesithing ya Limpopo mo ke dirago dithuto tša Masters Degree ka Clinical Psychology (MA Clin Psych). Seripa se sengwe sa dithuto tša ka, ke sa gore ke swanetše go dira dinyakišišo. Hlogo ya dinyakišišo tše ke di dirago e balega ka tsela ye: **"An exploration of the treatment of mental illness by indigenous healers in Moletjie, Capricorn District, Limpopo Province"**. Maikemišetšo a lesolo le ke go kwišiša ditsela tseo ba alafago bolwetši bja monagano ka gona.go

Lengwalo le ke la go kgopela tumelelo go lena gore ke kgone go dira dinyakišišo tše le di ngaka tše di ingwadišitšeng le mogathlo wa lena. Go bohlokwa gore dingaka di tsebe gore dikarabo tša bona go diputšišo tše di tla tshwarwa ka mokgwa wa sephiri. Monyakišiši o tla leka ka mešegofela gore a seke a ba amanya le dikarabo tše ba tla di fago, le ge ele go se utulle maina a bona bjalo ka motšea karolo lesolong le. Ba tsebišwa gore go tšea karolo ga bona go lesolo le go dirwa ka boithaopo, le gore bana le tokelo ya go ikogela morago nako efe go ba efe.

Diphetolo tšeo batšea-karolo ba di hlagišago ba tla boledišana le monyakišiši a le tee ba bonana mahlong.

Ka boikokobetšo

Phuti Mashamaite
Masters Student

Date

Prof. T. Sodi
Supervisor

Date