# CONCEPTUALISING MENTAL DISTRESS FROM AN AFRICAN PSYCHOLOGY PARADIGM: USING AN INTERPRETATIVE PHENOMENOLOGICAL ANALYSIS OF THE VIEWS OF TRADITIONAL HEALERS

A thesis submitted in partial fulfilment of the
requirements for the degree of

**MASTER OF ARTS IN COUNSELLING PSYCHOLOGY**

of

RHODES UNIVERSITY

By

**SANDISIWE SIFANELWE NABO-BAZANA**

ORCID NUMBER: **0000-0002-5283-5945**

Supervisor

**PROFESSOR JACQUELINE AKHURST**

March 2022

# Declaration

I declare that this thesis, *Conceptualising mental distress from an African Psychology Paradigm: using Interpretative Phenomenological Analysis of the views of Traditional Healers*, is my own work. As far as I am aware, this study does not infringe on the copyrights of others, nor does it violate any intellectual property right. All the sources or quotations are indicated or acknowledged, and a list of references is provided. The thesis is submitted in partial fulfilment of the Master of Arts in Counselling Psychology requirements at Rhodes University. It has not been submitted before for any degree or examination to any other platform.

……...

Sandisiwe Nabo-Bazana

March 2022

# Dedication Page

***This study is dedicated to my late sister, Qaqamba Khanyisa Nabo. Your passing made me more interested in understanding mental distress from a holistic perspective. May you keep shining in our hearts.***

# Acknowledgement Page

As I approach the final stages of writing up the study, I would like to thank several people who made this study possible.

- I would like to thank my supervisor, Professor Jacqui Akhurst, for your patience and wisdom during this process. Your input is valued, and you made this all possible, as I have learnt quite a great deal from you.
- I would like to thank Ms Lulu Mkhumathela, Ms Lindelwa Mqalo, Ms Nomtha Mqalo and Mr Khayalethu Mqalo for assisting me in searching for participants. Your support and assistance are highly appreciated.
- I want to thank all the participants who participated in this study. Your willingness is all so touching. May you continue to do so for other future researchers interested in this phenomenon. *Ndiyabulela*, thank you.
- Thank you to my colleagues for the continued support and friendship.
- A big thank you to my parents, Mr S. Nabo and Mrs Nabo, for your continued support and love.
- Most importantly, I thank my husband, Sandiso Bazana, for your support and love. Thank you for always being there to be my second pair of eyes. Your patience through all of this is tremendous. I love you.
- I want to especially thank my two warriors, Musa and Samora. It's incredible how understanding and patient you were when mommy couldn't be present at times. I hope you will take the baton one day and do even more outstanding work. *Ndiyanithanda*, I love you.
- Finally, I thank my Lord and Saviour, Jesus Christ, who has been with me through burnout and emotional and mental fatigue. I drew strength from what you provided for me.

# Abstract

With South Africa's long history of colonialism and racial oppression, there are still services in the country that many South Africans cannot relate to, including psychology. Research shows that many South Africans experience and are affected by mental distress due to several factors, including poverty, unemployment, and traumatic experiences. Managing and treating such distress has always been challenging for most South Africans. Some debates question the relevance of psychological services from the West in a South African context.

This study explores other approaches to psychology that look beyond the Biopsychosocial model when dealing with certain types of disorders in an African context. African psychology, or the Afrocentric approach, looks at what is beneath the surface, not just the presenting problem. Mainstream psychology strives to be universal and applicable to all. However, African psychology disagrees with this notion. African psychology perceives human beings as strongly influenced by social and cultural influences. The focus of this approach includes the spiritual realm and the attached meanings. There is evidence for the need to merge Traditional and Western medicine.

The research methodology for this study is qualitative, using Interpretative Phenomenological Analysis. IPA allows for a critical engagement with the ways in which participants construct their reality. The researcher carried out semi-structured interviews to enable participants, all traditional healers (3 female and 2 male), to narrate their experiences dealing with mentally distressed clients. The accounts of these traditional healers were analysed focusing on people who have experienced mental distress. From the analysis and synthesis of the themes, findings illustrate how traditional healers conceptualise and construct mental distress from an African Psychology paradigm. An emerging core theme was the importance of the divine call and its influence on the chosen treatments. More studies are needed to illustrate the potential for collaboration between African Traditional healing and EuroAmerican healing practices, to provide holistic services to people in need.

**Table of Contents**

## List of Tables

# CHAPTER 1: INTRODUCTION

## 1.1. Context

The focus of counselling psychology (CP) emphasises the social justice project. Bantjes et al. (2016) state that CP has maintained a social justice agenda throughout its history, striving to create a just society by challenging injustice, discrimination, and inequality. Rudd (2013), writing from the United Kingdom, states that the heart of CP lies in understanding psychopathology. However, according to the Standard Generating Body that delineates the scope of practice for CP in South Africa, psychopathology lies outside the CP domain (Bantjies et al., 2016). These contradictory points raise tension regarding the scope of competencies of CP, but even more critical is how African centred worldviews are located in the quest for social justice and constructions of psychopathology.

This dilemma is relevant to South African debates concerned with transforming psychology and engaging with African-centred worldviews. African centred worldview does not seem to be reflected in the scope of competencies. As a trainee Counselling Psychologist, I was confronted with this dilemma as I entered the professional programme. As someone born in African society, I was brought up with an understanding and belief that "*umntu ngumntu ngabantu",* which loosly translate to a person is a person because of others. The essence of living is to cooperate with others and not compete with them. For instance, those regarded as "*amageza*" (mentally ill) live amongst community structures. They socialise with others, and the illness does not call for isolation. This has sparked a lot of questions that led to this particular study.

Nwoye (2015b) argues that the tendency adopted in the African paradigm of mental distress is to view each of these unusual presentations or illnesses not as a common illness, but as problems that carry hidden meanings that must be decoded before attempting to cure what is on the surface (mental distress). At times this means that one must approach someone who has the gift of speaking to the supernatural powers, including a traditional healer (e.g. *inyanga*, *sangoma* or *umthandazeli*, definitions

provided in chapter 2). Therefore, this locally embedded study explores how traditional healers perceive and make sense of mental distress.

According to Bantjes et al. (2016), Counselling Psychologists focus on assessing, diagnosing, and intervening with clients dealing with life challenges and developmental problems to empower clients' psychological well-being. Counselling Psychologists are therefore concerned mainly with mental health and well-being development as if the two domains of mental distress and mental health are and can be easily differentiated. The assumption here is that mental distress requires medical investigation and clinical diagnosis for treatment. This assumption is debatable since many researchers, including Macleod (2004) and Nwoye (2015a), indicate that we live in a postmodernist society with more than one truth: psychopathology and the DSM-5 categories of mental disorders are said to be culture-bound within the Western World. Nwoye (2015a) notes that certain disorders may only be relevant in certain countries, but not in others. As Njenga (2007) points out, an example of this is anorexia nervosa, one of the leading causes of morbidity and mortality in adolescent girls from Western countries, which may not be the case in some countries in Africa, where the expectation is that if there is food you eat to the full.

Researchers like Long (2016) argue that we are in a post-colonial era and must cultivate a deeper understanding of indigenous societies outside the EuroAmerican spectrum. For example, the concept of psychopathology does not accommodate other mental distress that lies beyond the scope of practice of traditional EuroAmerican Psychology. Nwoye (2015a) argues that the Africentric approach reads accounts of mental illnesses as texts that carry meaning. This suggests that sudden acute symptoms of psychological distress are approached as meta-communications to be "read" and interpreted, rather than categorised and classified as emphasised by the DSM-5.

In this study, we take seriously Nwoye's intervention and emphasise the postcolonial context and in particular, the African-centred view of CP. We attempt to understand and contextualize the worldviews of traditional healers who operate 'outside' of the scope of CP as delineated in Rudd (2013, as cited above). We use African Psychology and the

Afrocentric paradigms interchangeably as they refer to similar ideas of placing African meaning-making at the centre. Mazama (cited in Nwoye (2015a) explains that the Afrocentric paradigm refers to the ideology that guides the epistemology to research and practice in contemporary African-centred scholarship. The Afrocentric paradigm contradicts the essentialist and ethnocentric views of 'Eurocentric' tendencies.

According to Mzimkulu and Simbayi (2006), the Eurocentric tendency to focus its aetiological explanation of mental distress on three possible sources of human disturbances: biological, psychological, and social domains, is insufficient when dealing with certain types of culture-specific syndromes as encountered in Africa. Nwoye (2015b) states that the term psychopathology has limited explanatory power since the Bio-Psycho-Social model is unable to accommodate some African experiences of psychological illness, such as "amafufunyana".

Moshabela et al. (2016) explains that the biomedicine approach to healing focuses on one treatment that will benefit the highest number of people diagnosed with a disease. What separates indigenous healing traditions from the biomedicine approach is that the former focuses on bringing balance to mind, body, spirit, and community. Baloyi and Ramose (2016) indicate that the Eurocentric paradigm of mental illness misses the spiritual perspective encompassed in the Afrocentric paradigm. This illustrates how biomedicine and indigenous healing traditions view mental distress differently. All these authors do not deny the effectiveness of existing understandings of psychology or the treatment of it in Western countries. However, there are likely to be differences when working in countries such as SA, where Eurocentric views do not prevail.

According to Idemudia (2015), African Psychology is embedded in principles that incorporate religion and spirituality. Engel (cited in Nyowe 2015b) explains that the Afrocentric paradigm recognises the possibility of mental distress arising not only from the mental distress of the body, the mind or social contexts but also from the spiritual or ancestral background of the individual manifesting the disturbances. Within the African perspective, healing comes through achieving balance and harmony within the different

spheres of an individual. Emphasis is placed on communicating with spirit beings. Regarding "amafufunyana", Niehaus et al. (2004) state that it is a culture-specific descriptive term used by traditional healers to explain unusual behavioural and psychological phenomena. Idemudia (2015) explains that any form of psychology teaching or psychotherapeutic practice without cultural aspects is incomplete. This study proposes to look at cultural explanations and justifications by exploring the experiences of traditional healers when dealing with mentally distressed clients.

## 1.2. Research Aim

This study explores how traditional healers conceptualise and make sense of mental distress through their lived experiences when dealing with clients presenting symptoms of mental distress. The research study aims to explore the following research questions:

- What are traditional healers' lived experiences as healers, and how do they understand the concept of mental distress?
- What methods and processes of healing do traditional healers utilise for dealing with mental distress in their practices?

The study is based on Interpretative Phenomenological Analysis (IPA). IPA is a contextual approach rather than an abstract approach. IPA involves a detailed examination of a person's worldview and investigates personal experiences and perceptions. Smith (2003) states that the researcher in IPA has a dynamic role in entering participants' worlds and understanding how participants make sense of their worlds.

## 1.3. Research Design and Methodology

This study seeks to take an exploratory approach. Babbie (2007) states that exploratory research is appropriate for understanding phenomena that have not been extensively studied before. Since the study looks at how traditional healers comprehend mental distress based on their personal experiences, the researcher sees it suitable to use an open-ended qualitative research study. Pathak et al. (2013) explain that a

qualitative approach focuses on understanding a research query from a humanistic approach. It looks at understanding people's beliefs, experiences, and attitudes as they interpret them.

The study used telephonic interviews due to the COVID 19 pandemic. Cachia and Millward (2011) argue that telephonic interviews are no better or worse than those conducted face-to-face and that they are an appropriate model for collecting sensitive information. The sensitivity of the information arose in this study when participants shared deeply personal and ancestral ‘secrets’ that are not generally divulged. These interviews took approximately 45- 60 minutes. The data was collected using semi-structured interviews. The information was translated into the language that participants were comfortable with, either English or IsiXhosa (both are languages the researcher is fluent and comfortable with). The interviews were audio-recorded, while the researcher also took notes and observed the participants' non-verbal communication. The researcher also engaged in personal reflection while collecting and analysing data in the process. A practical tool that the researcher required for this was probing skills that encouraged the participants to give in-depth descriptions of their lived experiences (Kvale & Brinkmann, 2009).

The target was five traditional healers from Makhanda and other surrounding towns such as Gqeberha, East London and Dimbaza. The participants were all traditional healers who had been practising for longer than two years and were older than 20 years. These participants were selected from the target population, and non-probability snowball sampling was used.

## 1.4. Ethics

Orb et al. (2000) explain that the challenges that many qualitative researchers encounter could be minimised by using well-established ethical principles, specifically autonomy, beneficence, and justice. Each of these will be further explored in chapter 3. According to Orb et al. (2000), benevolence includes doing good to others and preventing harm. Participants were allowed to withdraw from the research study should they wish to

do so. The researcher always consulted with her supervisor to identify any potential risk during the project activity. The potential benefits of the study outweighed the potential risks. It is hoped that the participants' contributions will help bring insight to many people interested in the phenomenon.

## 1.5. Definition of terms

### Mental distress

Cromby et al. (2013) use mental distress as a preferred term, instead of psychopathology or mental illness. The purpose is to see distress as a heterogeneous set of experiences and problems in their own right, not just symptoms of an illness. An Australian organisation formed two decades ago, Action on Disability within Ethnic Communities (2003), defines mental distress as difficulties that may lead to cognitive and emotional disturbances, changes in behaviour, relationships with others, workplace and home, and leisure activities.

### African psychology

Ratele (2017b) claims that some academics and practitioners reduce African psychology to be psychology centred only on Africans. However, Ratele (2017b) describes African psychology as being more conclusive: all of the psychology done in and for Africa, about Africans and non-Africans (working in Africa).

### Afrocentric Paradigm

Asante (1991) proposes that Afrocentricity is a frame of reference wherein a phenomenon is viewed from the perspective of an African; it means that every person is encouraged and enabled to see their world and its people from an African perspective. Mazama (2001) contends that Afrocentricity is about making black people aware of the achievement attained by their people and not always focused on oppression encountered. As much as Afrocentricity is involved in knowledge-building, it is also about ensuring the empowerment and liberation of African people (Mazama, 2001).

**African worldview**

According to Juma (2011), the term refers to traditional cultural and belief systems that highlight indigenous forms of understanding human nature and healing methods. This includes how people understand and make sense of human nature and healing methods from an African perspective.

**Indigenous Knowledge System** (IKS)

This term refers to the multifaceted set of knowledge, skills and technologies existing and developed around specific conditions of populations and communities indigenous to a particular geographic area (Noyoo, 2007).

**Divine calling** (*ukuthwasa*)

Many definitions explain and describe the process of divine calling (better known as *ukuthwasa*). Booi (2004) states that it is not an illness per se but a state of calling to become a traditional healer. Mabona (cited in Mlisa, 2009) defines *ukuthwasa* as an action verb that means to enter into the initiation process, emerging from a new moon, and becoming a new person. Mabona also explains *intwaso* as a noun describing both the emic and etic symptomatology or characteristics of *ukuthwasa.* It is seen as a process of transitioning from the mortal world to the immortal, becoming an intercessor between the living and the non-living beings. The condition signifies a spiritual inclination towards both hearings and seeing the unseen world.

**Traditional healers/ Indigenous healers**

This is a term used to refer to people who practise traditional ways of healing. These people are culturally recognised for their care and treatment of various disorders. They are often also called traditional healers or *isangoma***.** Mpono (2007) posits that they are regarded as individuals specializing in healing psychological, social, emotional, spiritual and holistic problems.

## 1.6. Outline of the study

In chapter one, the aim was to lay the groundwork of what the study is all about. It is a summary of what the study entails. It presents the study's objectives, giving context to what has been done and where the gap lies. The study seeks to conceptualise mental distress from an African Psychology perspective, using IPA of the views of traditional healers.

Chapter Two reviews literature that relates to the current study. It also seeks to outline the field of African Psychology and what it entails.

Chapter Three illustrates what IPA is, as a framework and method of analysis. It also focuses on how ethical issues were addressed. The research methodology section outlines the most appropriate methodology, including the research design used to explore the research questions. It then outlines the methods and data collection tools implemented to carry out the study.

Chapter Four: The biographical data of the participants and the research findings are presented in this chapter. The research questions are systematically covered, providing evidence of participants' responses regarding each.

Chapter Five: This chapter discusses the findings gathered from the study linking these to the extant literature and highlighting important aspects for consideration.

Chapter Six: After a final summary of the study, this chapter explores the recommendations and limitations of the study for future reference.

# CHAPTER 2: LITERATURE REVIEW

## 2.1. Brief historical background

Trying to understand, conceptualise and apply psychology in Africa is a great struggle, bringing fascinating experiences and revealing insight into various relationships. Scholars such as Fanon (1952) have played a considerable role in helping understand the impact of oppression on mental health. Butts (1979) claims that Fanon argued that mental illness is influenced by society and culture. Such ideas opened up possibilities of linking mental distress to the intractable contradictions of colonial and post-colonial societies. Briefly looking at what might be termed the history of the discipline helps provide a background to the research topic. As a novice psychologist, I explore this to comprehend what has emerged in the profession that I want to pursue. It is vital to acknowledge that what is noted in this study is just a brief understanding of the history of psychology in SA.

With SA's long history of colonialism and racial oppression, the role of psychology in the country has always been opaque to many people. Certain services in the country were inaccessible to most South Africans, and they could not relate to them, and psychology was no exception. Macleod (2004) indicates that psychology was accused of being irrelevant and intentionally or unintentionally supportive of the apartheid system. Dawes (1998) also states that during the apartheid era, the psychology profession was rightly castigated for its apolitical silence and for not bringing its intellectual resources to bear on the psychology of oppression in SA. Psychology in the apartheid era failed to tackle the social injustice in SA. Instead, it appeared to support, through its inaction, the mistreatment of one group of people by the other. According to de la Rey and Ipser (2004), psychology benefited only the middle-class white person. It, therefore, discriminated against the majority, referred to as the Black (most South Africans were not classified as white).

Counselling psychology (CP) forms part of psychology's broader discipline. The history of CP is much narrower and more restricted, and as Bantjes et al. (2016) describe it as poorly documented. How counselling psychology developed in SA is entrenched in

historical agendas. It has been influenced by the history and impact of the apartheid era in the country. Leach et al. (2003) note that clinical psychology in SA was connected with the English speaking and more progressive psychology departments. In contrast, Afrikaner academics wanted their psychology linked up with Nationalist government ideologies which included: career issues, job opportunities, health development, prevention and a future-oriented approach directed at promoting Afrikaner speaking. With such statements, one could argue that psychology in SA had its own agenda. The agenda did not necessarily prioritise working towards making sense of human behaviour for the well-being of the majority of individuals. Instead, this agenda seemed to be a contest between the English-speaking and Afrikaans, creating ideologies that would benefit the apartheid regime. CP was established as a subfield less threatening to the Nationalist government than clinical psychology, but supporting white and Afrikaner development (Leach et al., 2003). Such arguments illustrate how psychology failed to be effective or far-reaching in the country's most oppressive and critical time, and its relevance today is impacted by the legacy of such influences, leading some to continue to mistrust the discipline.

## 2.2. Relevance debate

The relevance debate can be defined as a discourse emphasising the need for the discipline to become more socially valuable to the people who purportedly need it (Sher, 2012). According to Macleod (2004), the relevance debate emerged during the late apartheid era. The emergence of the relevance debate in psychology was the seeming lack of discipline to add social value to the majority of the people in SA. Macleod (2004); De la Rey and Ipser (2004) commented that the relevance debate was formulated by a group of psychologists who questioned the applicability of psychological practice in SA. Researchers including Macleod and Terre Blanche et al. (2004) indicate that the relevance debate was not only encountered in SA. A crisis was also identified within the international arena concerning the degree to which the Eurocentric "Western" tradition of positivistic empiricism in psychology could be regarded as relevant to people's everyday lives in vastly different social contexts (De la Rey & Ipser, 2004). The purpose of doing this is to discover the similarities and differences between the two worlds. Sher (2012)

argues that such similarities suggest that the emergence of the relevance debate is contingent on particular circumstances; therefore, there is a socio-historical dimension to such a discourse.

Sher (2012) argues that similarities can be found in how both the USA and SA need modification within the psychology discipline to address the social issues present within society. A shift from the biomedical models, which emphasise rigorous scientific methods and an individualistic approach, is needed towards a more fluid understanding of the impact of social context on mental health. Both the USA and SA need to develop methods within the discipline of psychology that will shake up the existing traditional biomedical approach, with the predominance of the individualistic lens. This includes being more concerned about the social ills that plague both countries. Particularly issues such as crime, poverty, unemployment, HIV and AIDS, race, and class, need attention due to their widespread impacts on mental health. According to Lund et al. (2008), there is a need to step up implementation of the legislation in SA, to adopt a national mental health policy and to translate policy into service delivery aimed at addressing critical developmental priorities such as poverty, unemployment, social supports, HIV/AIDS, crime and violence. They claim that mental health is a critical issue resulting from many of these challenges. Lund et al. (2013) also mention the impact of lost income, particularly unemployment, on the mental health of South Africans. Mkhize (2020) reports that early twenty-first century SA politics is characterised by rhetorical self-importance around racial and economic inequalities, with many living below the poverty line, and the lack of services for the majority. This makes things harder for marginalized groups with limited health resources to have access to public health facilities.

## 2.3. The current state of psychology in SA

Much has occurred since the end of the colonial and apartheid era, with psychology subsumed as a profession under the health care system. Mkhize (2020) argues that the coming of democracy to SA in 1994 was also reflected in significant transformations in the discipline and profession. The discipline was under the spotlight, and change had to be implemented. Mkhize (2020) claims that in the spell of institutional transformation that

characterised early post-apartheid SA, the white-dominated PASA (Psychological Association of South Africa) was disbanded, and a more inconclusive body Psychological Society of SA (PsySSA), was founded. Mkhize (2020) notes that the vast majority of people in PsySSA were white. However, the leadership positions of the body were occupied by black psychologists. In some ways, this strategy created a façade for transformation. The strategy helped the body earn recognition, and PsySSA gained favour with international bodies such as the International Union of Psychological Sciences.

Leach et al. (2003) report that a professional board for psychology was devised to report to what was then known as the Medical and Dental Council, but now reports to the Health Professionals Council of South Africa (HPCSA). Although many black students in the professional programs have recently been recruited, only a quarter of registered psychologists are catagorized as black (Cooper cited in Long, 2017). Many higher learning institutions offer training at a Master's level for Clinical Psychologists, Counselling Psychologists and Educational Psychologists, Research and Industrial Psychology students. Each discipline is circumscribed by a Standard Governing Body document that limits overlaps with other fields.

Mkhize (2020) states that psychology is taught as an extension of the Eurocentric psychological paradigm in most African universities. This means that the psychology taught in Universities during the colonial era may still be similar to psychology taught in this democratic era. Long (2017) augments this by saying psychology's irrelevance to black working-class problems has alienated black students from the discipline, e.g. non-issues of poverty in clinical psychology literature, despite its links with two of the biggest psychosocial problems facing the country, namely violence and HIV/AIDS pandemic. Mkhize (2020) reiterates that the existing training curriculum progressively alienates Black/ African students from historical and cultural backgrounds.

Baloyi and Ramose (2016) state that in their view to that point, indigenous knowledge systems, particularly African experiences, are only used as examples to justify Western

theories' imposed authenticity, applicability, and usefulness. Students are faced with the predicament of shifting away from their cultural backgrounds for the period of training. When forced to return to their communities, they cannot relate their training to the psychological problems presented in front of them. As I reflect on my experiences, the foundational theories taught during my undergraduate years were those of Sigmund Freud, Eric Erikson, Jean Piaget, to mention but a few, making students question how much the discipline was related to experiential reality. The battle begins when the social context of the theory is not relatable to that which is known. As a result, many students were poorly prepared for this intellectual, theoretical, concept, and methodological task (Mkhize, 2020).

According to Mkhize (2020), misorientation, the social, cultural, and economic distancing of Black African psychologists from communities that have raised them, is one of the major challenges limiting the provision of psychological services to the majority of the Black population. Students can no longer relate and adjust to what they left behind and end up relocating and practising in the cities where they were trained. This results in making psychology seem irrelevant and inaccessible to people in rural areas of SA, especially those dealing with traumatic experiences.

SACAP (2019) states that one in six South Africans suffers from anxiety or depression, excluding psychosis or substance use problems. Added to this only 27% of South Africans with severe mental illness have received treatment, and 40% of people living with HIV/ AIDS in SA have a diagnosable mental disorder. Based on the statistics presented, one can assume that the current state of services to enhance mental health in SA have been characterised by inefficient interventions. SACAP (2019) further notes that in low-income and informal settlements in Cape Town, 1 in 3 women experiences symptoms of postnatal depression. These are cases that have been recorded, and there could be more that are undocumented. Nguse and Wassenaar (2021) report that mental health has been treated as an external and insignificant part of the health sector. Mental health care in SA appears not to be seen as a priority, and many cases are not reported. Those that are reported are not all treated. The primary burden of mental health care falls

on community-based providers, including clinics, support groups, lay counsellors, and community leaders who have to step in where institutionalized help is not available (Chambers, cited in SACAP, 2019).

HIV/ AIDS and other health problems pose a significant challenge for the country's mental healthcare system. Studies done to establish a causal relationship between mental health and the impact of HIV in developing countries indicate an absence of reliable and recent mental health epidemiology (Freeman et al., 2008). SA has the highest prevalence of HIV/AIDS globally, and AIDS contributes to deteriorating employment opportunities, affecting productivity, increasing crime and poverty, and destruction of families (Lund et al., 2012). The surge of HIV/AIDS in the country has led to increased demand for mental health workers. The mental healthcare system has been inadequately resourced, and more and more need access to fully resourced healthcare facilities.

In addition at the current time, the world is faced with another pandemic that affects many people's mental and physical well-being across the globe. The fear and terror of Covid-19 has left many financially, mentally and physically affected. Since SA is still a developing country, it was not prepared for what has come, seeing that it is still recovering from the past traumas encountered. Nguse and Wassenaar (2021) state that the virus coincided with a prolonged public health crisis in SA; it has amplified the existing mental health gap and constrained access to mental health care services. As many were restricted from going about their business, many could not use health care facilities. Nguse and Wassenaar (2021) report that Covid-19 contributed to many people losing their employment, an increase in Gender Based Violence in the first week of the first lockdown, and lack of health care facilities only being used for those in critical conditions. This left many in fear of their and their loved ones' well-being, increasing the country's mental health crisis.

Despite the claims of transformation and change in SA, relevant interventions need to occur for many South Africans. SACAP (2019) stresses that the mental health situation in the South African context requires South African solutions. Solutions need to be

effective and benefit most people with limited resources. Because of this excessive responsibility that falls on community healthcare providers when dealing with mental illness, Chambers (cited in SACAP, 2019) proposes that the crisis needs a holistic approach that will incorporate the western and the traditional methods. According to Nattrass (cited in Sorsdahl et al., 2009), several studies have proved that alternative practitioners might play an essential role in addressing mental health care needs in SA by offering culturally appropriate treatment. To curb the overwhelming need for assistance with mental distress in SA, many current workers providing resources and services to assist, including traditional healers, nurses, counsellors, and coaches need to be at the forefront.

Sorsdahl et al. (2009) highlight that for many people still immersed in their own traditional African belief systems, mental health problems are perceived to be caused due to ancestors or bewitchment. Traditional healers and religious advisors are viewed as having expertise in these areas. This study seeks to understand how a sample of these traditional healers make sense of mental distress, in order to see how psychology might work in collaborative ways with the traditional healing system.

## 2.4. Traditional healers and the role they play in society

Before the arrival of the missionaries in Africa, Africans used alternative methods for healing. This did not include going to the doctor to be examined. The means of such healing are now more controversial, given the predominance of westernized approaches to medicine. This includes consulting of Traditional healers or *sangoma*'s ( to be further described below). Kale (1995) confirms that traditional healers existed in SA before its colonisation by the Dutch in the 17$^{th}$ Century. McFarlane (2015) adds that traditional healers were accused of practising witchcraft during the colonial era (in which Christian views were predominant, which led to the extinction of the practice across various regions in Africa.

According to McFarlane (2015), SA has three forms of medical treatment which are Western European medicine (known as allopathy or biomedicine), Indian traditional

medicine and African traditional medicine. The World Health Organization defines African medicine as a health practice, approach, knowledge and beliefs incorporating plant, animals and medicines, spiritual therapies and manual techniques, exercises applied to treat, diagnose, and prevent illnesses or maintain well-being (McFarlane, 2015). This form of healing is characterized by the absence of biomedical substances and practices. According to Mokgobi (2012) the majority of people's health care needs would be affected if the traditional health care system were not in existence. Moodley et al. (2008) stipulate that traditional healing aims to restore, bring harmony and balance for individuals through the body, mind and spirit. Through this equilibrium traditional healing seeks to offer a holistic conceptualization of health and well-being between the individual and the environment they are in. In the colonial era traditional African methods have been described as useless by the Europeans, promoting social stigmas; however, more recently government policies and scientific advances have shaped African traditional medicine as more acceptable to society and healers have been incorporated into approaches to deal with diseases such as HIV and AIDS (McFarlane, 2015).

**Types of Traditional healers**

Traditional healers are the designated psychologists in African society such as South Africa, and rural Africans prefer visiting said healers (Long, 2017). These said healers are trusted by the communities and their practices have been around for centuries. Traditional healers in indigenous societies are known as people who tend to have the ability to convey messages that have a more profound meaning than what is at face value.

Just like medical doctors are not homogenous, so are traditional healers. Each has a speciality within which they are gifted and trained. In the case of traditional healers, this speciality is determined by their ancestral instructions and those of their mentors. Healers do so through dreams (*ithongo or amaphupha*), visions and revelations; for others, it is through throwing bones, and the bones reveal what should be done. The following categories of traditional healing are found:

- *Inyanga/Ixhelwe*: they are herbalists, and they possess the skill and knowledge of mixing different herbs for curing a specific ailment. Kale (1995) notes that most herbalists are males.

- *Isangoma* or *iqhirha*: These practitioners are called diviners. They are the ones who assess, diagnose and treat clients or patients. Kale (1995) clarifies that diviners diagnose the cause of illness or diseases. Diviners apparently cannot choose to be diviners, they are said to be chosen by supernatural beings. Further, a person summoned to be a diviner behaves like a person with a mental disorder and only a skilled diviner knows the difference between the two, and 90% of diviners are females.
- *Umthandazeli*: this is a faith-based healer. They heal by their Christian faith and relations with the Creator. According to Kale (1995), they heal through prayer, holy water or ash, by touching the client. They can also use other healing methods, such as burning candles.

All these categories fall under the umbrella term traditional healers or indigenous healers. These are the people communities consult for ailments, especially in rural areas.

## 2.5. The role of traditional healers in mental health

Gwala (2021) reports that there are about 200 000 traditional healers in SA and only 975 psychiatrists in urban areas and private practice. These are recorded and registered as traditional healers, excluding those not recorded. Gwala (2021) further explains that the problem is that 80% of the population are dependent on the public sector with limited mental health care services. According to the Medical Research Council (cited in Gwala, 2021), 80% of South Africans consult traditional healers. That means that medical professionals deal with a smaller percentage of people who are experiencing mental distress. Collaboration would mean that both traditional and Western practitioners work together educating each other. Acceptance of traditional practices in SA would relieve a substantial burden on the mental health care system. Mhlongo (cited in Gwala, 2021) notes that traditional healers are the first option for people living in townships, but their services can only go so far. She also believes that collaboration between western and traditional practitioners would benefit the community this follows similar suggestions in other African contexts, such as Wamba and Groleau (2012).

Traditional and spiritual healers can play a crucial role in early identification, referral, and sharing cultural understanding with treatment-resistant patients who could be referred to alternative treatment modes (Dikobe-Kalane, cited in Gwala 2021). A combination of both the western and traditional methods could minimise the influx of patients to public mental health facilities in the country. Only those with severe conditions such as chronic depression, schizophrenia and bipolar disorder, could then be referred to mental health care facilities.

## 2.6. African(ization) of psychology

According to Mkhize (2004), Western psychology is interpreted as being value-free, objective and universal. This means that mainstream psychology perceives human beings as independent subjects separated from social and cultural influences. Zikalala (2017) posits that mainstream psychological worldviews, theories and ideologies are deemed to be universal and applicable to all; however African psychology disputes this notion. Many scholars have battled with this notion as they emphasised the human being as inseparable from their social and cultural environments. African psychology came into being because people did not agree with some of the views and ideologies that mainstream psychology stood for. Since then, many local and international scholars have discussed African perspectives and ideologies to psychology and understanding mental distress.

Among many other writers, Parle (2004) sparked an interest that continues today. This historian investigated broad representations of mental health in KwaZulu-Natal across ethnic groups. One writer who reviewed her work is van Ommen (2007). According to van Ommen (2004), Parle returns to the context of colonial Natal and Zululand from a different angle. In Parle's (2004) research and account, she illustrates the historic role of psychiatric biomedicine in mental health. She writes a broader history, including the numerous alternative healing practices in African, Indian, and European communities. Van Ommen (2007) further explains that this displacement of the dominance of colonial psychiatry through demonstrating its limits within a specific context, acts as a corrective to theories that promote an image of psychiatry as a "total institution", a discipline of

universal applicability. Parle's (2004) account illustrates the complexity of people's meaning-making concerning mental distress and that community groups take alternative approaches to the phenomena and their treatment.

Over the years, there have been disagreements about how mental distress is understood. For example, Njenga (2007) explains how anorexia nervosa is one of the leading causes of death for young girls in the West. He argues that this condition is hardly known in Africa, but it is considered as widespread amongst adolescent females in the West. In Kenya alone, over 320 years, there have been only 20 reported cases of anorexia nervosa (Njenga, 2007). Such instances have led to many disagreements among Black psychologists over Black or African psychology (Baldwin, cited in Cokley & Garba, 2018). Recently, there have been increasing debates about African Psychology and what it entails. Scholars such as Nwoye (2015), Mkhize (2020), Ratele (2017b), Long (2017), Makhubela (2016) and many others all have different views on the conceptualisation of African Psychology. Back and forth academic debates between Nwoye and Ratele can be found online, for example. Both scholars see African psychology differently and draw on theories that support their work. Nwoye (2015) positions the discourse as a new phenomenon recently explored. He believes that it is one of the latest additions in the register of post-colonial disciplines in African Universities. Nwoye (2020) further states that it is a new study within continental Africa's broad academic discipline of psychology. It can be defined as a systematic and informed study of the complexities of human mental life, culture, and experience. Ratele (2017b) however, argues that African Psychology is not something as new as it is made out to be. He believes it has existed for some time and is more connected than Nwoye (2015) positions it.

Ratele (2017a) continues by saying that Nwoye's objective is to contribute to the need for improved understanding, image, and advancement of African Psychology in African Universities and to modify any prevailing limited conceptions of its meaning and promise in the minds of colleagues within and outside of Africa. Part of this contribution recognises that the early efforts to entrench African Psychology as an academic discipline in African

universities were severely frustrated. Nwoye's (2015) stance introduces the African Psychology discourse to African universities, as it is currently wanting. However, Ratele (2017a) argues that African Psychology cannot be reflected without recognising the efforts of African American scholars in developing black psychology in the US. He comments that African Psychology emerged to understand African people's influences, struggles, conditions, costs, and achievements in the United States. Nwoye's work thus appears dismissive of the decades of groundwork by black scholars in the United States around the same questions and to develop African Psychology (Ratele, 2017). Cokley and Garba (2018) state that Joseph White described Black psychology in the 1970s as understanding the lifestyles of Black people based on their authentic experiences.

Nwoye (2015 ), however, contends that African Psychology is not the same as Black Psychology or African Indigenous Psychology. Nwoye (2020) asserts that African psychology studies multiracial Africans and their worlds. The thing that sets it apart from Black Psychology is that the former embraces members of the Black African population excluding those of Indian and White African descent. The idea of African-based psychology has raised concerns with scholars such as Moll, arguing against its generalisability to all Africans (Chitindingu, 2012).

Ratele (2018) explains that African psychology is not a separate body of knowledge but a way to situate one's work and self. This situated practice and knowledge is not a single thing but a dynamic enterprise. He reiterates that African Psychology is composed of different orientations. These include Western-oriented African psychology, Cultural African Psychology, Critical African Psychology, and Psychological African studies. Ratele (2017a) explains that Western-oriented African psychology is adopted by those who believe that psychology is universal. This forms mainstream psychology in SA, and this is the core content of what is taught in Universities, therapeutic modalities used in consulting rooms and psychiatric hospitals and published research. The second orientation is African Studies, which uses psychological and psychoanalytic methods, theories, tools, and insights. According to Ratele (2018), the third African psychology orientation includes a more culturally, spiritually, metaphysically, and philosophically

inclined African psychology. It situates the investigator and the examined, the therapist and client, the teacher and student in their cultural worldviews. The final orientation includes African psychology that seeks to be attentive to the materiality or structures of daily life, including economic and political and other social structures. These structures are seen as shaping psychology, and critical African psychology perceives itself as oppositionally situated such structures.

Ratele (2017b) posits that it does not help to look at African Psychology under one lens but one needs to consider the above array of approaches. These debates indicate that the discourse of African Psychology is not homogenous and that it is a discourse that continues to be examined. Makhubela (2016) expands the above by saying that it is not possible to be advocating for decolonisation without recourse to reclaiming the primacy of Africa to the knowledge of the Western world. He claims that Africa is the bedrock of Western knowledge, as the historical foundations of psychology were captured in the Egyptian Mystery System's theory of Salvation. Makhubela argues against being caught up with the West that blinds us from factual information. Dawes (1998) claimed that African Psychology should draw on both local and external knowledge systems rather than essentialist practices that result in petty outcomes and prevent the decolonisation of psychology. This means that instead of focusing on the injustice imposed upon Africans (including white Africans) by colonial dogmas, the discourse of African psychology should centre what has been done to benefit Africans. Long (2017) agrees that authentic African Psychology must address the inequality and violence that pervades the lives of ordinary South Africans, a task for which the principles of Fanonian psychology are well situated.

Fanon indicated that colonial racism impacted the mental health of those being oppressed. Zikalala (2017) contends that African psychology considers humans inseparable from their environments and that these elements should live in harmony. This means that African cultures emphasise spiritual aspects in combination with nature. The spiritual oneness with nature includes looking at how the environment can play a role in the psyche of a human being. According to Schauer et al. (2016), spirituality can be seen as a fundamental human drive for transcendent meaning and purpose that involves

connectedness with the self, others, and the environment they are in. This includes mental distress being caused by external forces outside the person's control, which means preternatural powers influence the mental state.

Researchers like Long (2016) argue that we are in a post-colonial era and must cultivate a deeper understanding of indigenous societies outside the Eurocentric spectrum. For example, the concept of psychopathology does not accommodate other mental distress that lies beyond the scope of practice of traditional EuroAmerican Psychology. As Nwoye (2015a) states, mental distress in Africa refers to critical mental illness problems, such as psychosis or schizophrenia, and irregular or strange behavioural presentations that often arise from mysterious origins. Standard explanations for the difficulties in ascribing meaning to these include declarations that psychology is incompatible with the African worldview.

## 2.7. What is Afrocentricity?

Asante (1991) defines centricity in education as a perspective that involves locating students within the context of their cultural references so that they can relate socially and psychologically to other cultural perspectives. Afrocentricity is a concept that stems from the school of African worldview that includes wholeness, community and harmony, which is embedded in cultural values (Dlamini, 2018). The approach proposes that blacks (at home and abroad) look at knowledge from an African perspective. It suggests looking at matters at hand from an African viewpoint; studying Africa outside of an African lens could be ineffective in comprehending what it is all about. Asante (1991) reiterates that Afrocentricity is a frame of reference wherein a phenomenon is viewed from the perspectives of an African; it means that every person is allowed to see their world and its people from an African perspective. When Africans view themselves as central in their history, they see themselves as agents, actors, and participants rather than as marginal and periphery of political or economic experience (Chawane, 2016). Afrocentricity is not a black version of Eurocentricity (Asante, 1991). Although not the opposite of Eurocentrism, Afrocentrism has become a controversial topic, with all scholars debating its practicality and non-practicality (Chawane, 2016). Afrocentricity, just like Eurocentricity, has its shortcomings that have been identified. Afrocentricity aims to

acknowledge and recognise diversity in people. Asante (1991) reports that it is a paradigm that is not anti-white but against racism and ignorance from all. Again Chawane (2016) asserts that it is high time Africans start seeing value in the self and appreciate what they have to offer to the rest of the world.

## 2.8. The rationale of the study

The focus of this study is to conceptualise how traditional healers make sense of mental distress. Hearing from these traditional healers' sense-making about mental anguish could provide a perspective that could help us as psychologists gain a holistic understanding of how mental distress is viewed and how people, especially those from the Eastern Cape SA, understand it. This will also provide deeper knowledge about reaching out to those who find psychology irrelevant and seek other treatment methods. Understanding how traditional healers make sense of mental distress will also provide a comprehensive understanding of why people seek the help of healers rather than the Western methods. This indicates how African ways of being have incorporated the means of seeking assistance, to enhance people's well-being.

## 2.9. Conclusion

In closing, this chapter gives an overview of relevant aspects of psychology's history in Africa and SA; and the current debates about its positioning. Psychology in the apartheid era failed to look at the social injustices in SA but instead often through inaction supported the mistreatment of one group of people by the other. Although transformation is noted and apparent in the discipline since 1994, a great deal more still needs to be done. The fight for better services to treat mental distress, appear now no longer to be mainly about racial inequality, but emphasise social injustices as experienced by the majority who do not have access to services that should be provided, as mandated by policy.

The mental health care system in SA has been impacted by limited resources and understaffing and the crisis is felt by those at the front line of mental health, as many

efforts go by unseen. The existing mental health facilities require assistance, and this assistance could include African-centred approaches, collaborating with those the community has access to, could reduce the extent of the problems.

# CHAPTER 3: METHODOLOGY

## 3.1 Introduction

The following chapter aims to describe the methodology used in the current study. This chapter seeks to explain and justify a research design that aims at understanding mental distress from an African Psychology perspective. The focus of the chapter is on the methodological paradigm, design, data collection, and analysis of the study. The chapter addresses how data was collected and analysed guided by the Interpretative Phenomenological Analysis (IPA) paradigm.

## 3.2 Qualitative Design

This study seeks to take an exploratory approach. Babbie (2007) states that exploratory research is appropriate for more complex phenomena. Terre Blanche et al. (2014) add that exploratory analysis makes initial investigations into relatively unknown research areas. One of the reasons for using this type of study is for the researcher to gain an insightful understanding of the world of traditional healers. Through these lived experiences, this is to judge how these specific people make sense of mental distress in non-western traditions.

According to Welman et al. (2005), the purpose of exploratory research is to gain some familiarity with the phenomenon without comparing it to others. Babbie and Mouton (2001) stipulate that exploratory studies are done for numerous reasons. I will discuss some based on my reasons for pursuing an exploratory study. One of the reasons mentioned is that research is conducted for exploratory purposes to satisfy the researcher's curiosity. The other is a desire for better understanding and testing the possibility of undertaking a more extensive study. Both these reasons spoke to why I wanted to use an exploratory approach as a way of better understanding the concept of mental distress and traditional healers and because of my interest in traditional cultural practices in the area and knowledge of people's positive attitudes.

As a South African IsiXhosa speaking woman, I have always been intrigued by the perceptions around traditional healers as well as the methods used to deal with mentally distressed individuals. I have often wondered about the impact of Western practices on more impoverished and less literate communities. As noted earlier, access to mental health services in some communities in South Africa is not as accessible as it would be in other countries, recognising that the role of psychology is not known about or widespread amongst the majority (Young & Saville Young, 2019). As a registered student psychologist, I enter this field with questions about a psychologist's role for someone who might have never heard about a psychologist and what they do. I question the impact I would have on a person who has been accustomed to a different way of meaning-making than what I am used to and what I know.

The core of this study is not to focus on the relevance of psychology in a marginalized community and with South African history, but to focus on how mental distress is understood by those who deal with individuals who use a different approach to healing than what traditional western psychology offers. In the end, I would like to look at ways to change how people see psychology in disadvantaged places in SA and make it more “relevant” and applicable to such areas. Such information may be achieved by going into the participants’ worlds and getting to know their perspectives. Maso (cited in Juma, 2011) explains that qualitative research assists the researcher to tap into the world of the participant as it is described, experienced, and constituted.

Pathak et al. (2013) explain that a qualitative approach focuses on understanding a research query from a humanistic view. It looks at understanding people's beliefs, experiences, and attitudes, striving to present these as they interpret them. As a qualitative researcher, the aim is not to dictate or direct subjects but to make sense of their worlds since they are viewed as having expertise.

## 3.3 Interpretative Phenomenological Analysis (IPA)

IPA involves a detailed examination of a person's worldview and investigates personal experiences and perceptions. Smith (2003) states that the researcher in IPA plays a dynamic role in entering participants' personal worlds and understanding how participants make sense of their worlds. Biggerstaff and Thompson (2008) accord Smith with credit for expounding IPA theory in beneficial ways in psychological research. The function of IPA is to allow a thorough exploration of idiographic subjective experiences and, more specifically, social cognitions.

In IPA, the researcher seeks to generate and explore rich and meaningful data related to specific phenomena, as experienced and reported by others. Fade (2004) also reports that IPA aims to gain as far as possible an insiders' perspective of the phenomenon being studied, while recognising the researcher as the primary analytical instrument. This means that the role of the researcher is both to assist in generating data and strive for more profound meaning-making through grouping and exposition of these data.

IPA is a contextual approach rather than an abstract approach. This means that a researcher has to observe the participant in the everyday environment, making meaning of their day-to-day activities. Smith et al. (2009) argue that IPA is grounded in three key areas of philosophy of knowledge: phenomenology, hermeneutics, and idiography. To make sense of IPA, one needs to understand these three fundamental philosophical areas that make up the framework. According to Smith et al. (2009), the founding principle of phenomenological inquiry is that experience should be observed in the way that it occurs and in its terms. To gain rich meaning, one needs to investigate people's descriptions of their experiences in natural settings.

For Husserl (1927), the core founder of descriptive phenomenology, it involves a careful examination of human experience and finding means by which experts know their *own* experience of a given phenomenon and do so with a depth and rigour which might

allow them to identify the essential qualities of that experience (Smith et al., 2009). It creates the core of the experiences of several individuals who have all experienced the phenomenon in question. Charlick et al. (2016) distinguish between descriptive and interpretative phenomenology. The former phenomenology aims to describe a lived experience without attempting to give meaning to it. The latter is all about interpreting the meanings embedded in lived experience. Cassidy et al. (2011) highlight that researchers using phenomenological methods aim to discover the meaning of people's experience of a specified phenomenon through focusing on a concrete experiential account grounded in everyday life. As the researcher interested in knowing more about traditional healers' lived experiences when dealing with mentally distressed clients, I am aware of personal experiences that might influence my perceptions. Thus, I needed to strive to combat these. I hence needed to approach the experiences wherever possible, with curiosity, hoping to be enlightened about the unfamiliar worlds of indigenous healing.

According to Smith et al. (2009), different perspectives to interpretative phenomenology argue that knowledge does not fall outside of interpretation. Heidegger (1962) explains that understanding the lived world can only occur through interpretations grounded in the world of things, people, relationships, and language (Charlick et al., 2016). This illustrates that the meaning that participants narrate will be based on how the researcher makes meaning of the narrative descriptions collected. Smith et al. (2009) then describe Merleau-Ponty's perspective as a "meeting point" between the self and the world, and that the idea of "other" advances from one's own embodied perspective. Researchers observe and experience empathy for participants but can never see the phenomenon only through the lens of the participant and share the other's experience. Smith et al. (2009) highlight that Sartre (1956) made essential contributions to phenomenology, with work focused on the self, not being a pre-existing unity waiting to be discovered, but a progressive project of always becoming oneself.

Biggerstaff and Thompson (2008) state that IPA's theoretical underpinnings stem from Husserl's attempt to construct a philosophical science of consciousness using Hermeneutics, the theory of interpretation. According to Alase (2017), Hermeneutical

phenomenology is a fusion of research participants' lived experiences (phenomenology) and the interpretation (hermeneutics) of the life they have lived and experienced.

The third major philosophical underpinning of IPA is idiography. Smith et al. (2009) state that idiography is concerned with the particular rather than being equivocal whilst maintaining the person's integrity, and this mainly operates at two levels. Firstly, there is a commitment to the specific, in the sense of detail, and therefore the depth of analysis. Secondly, IPA is committed to understanding how particular experiential phenomena (an event, process or relationship) have been understood from the perspective of specific people in a particular context (Charlick et al., 2016). Idiography avoids generalisation. Due to this, IPA studies tend to focus on small samples that are purposively selected.

Alose (2017) points out that IPA is a "participant oriented" approach. It encourages the interviewees (research participants) to express themselves and their "lived experiences" as they see fit, hoping that aspects of the interview will not distort these. Because participants are viewed as experts in their worlds (as noted earlier), the researcher must not push their agenda or perspective in the narratives as told by the participants. As a novice psychologist looking into the lived experiences of traditional healers, who deal with mentally distressed clients, I do not want to bring in the perception of "I know better, or I am a better suited professional" than they are. Instead, I seek to enter their worlds of meaning-making, approaching them as experts using non-traditional ways of dealing with mentally distressed clients. According to Smith and Osborn (2015), IPA is helpful when investigating complex, ambiguous, and emotionally packed topics. For this reason, I decided to use IPA as an approach that will help better understand this complex and unique way of healing.

## 3.4 Ethical Considerations

Resnik (2020) highlights that ethics in research are principles that guide research designs and practices. Scientists and researchers must always follow a specific code of

conduct when collecting data. These codes of conduct include ensuring that the proper protocols are followed when working with people and that the research subjects are not harmed in any way. Resnik (2020) argues that research ethics matter for scientific integrity, human rights and dignity, and collaboration between science and society. These principles ensure that participation is voluntary, informed, and safe for research subjects. Ethical clearance involves making explicit the purpose of the research; descriptors of each method of data collection and type and characteristics of the sample; the nature of the interaction(s), their frequency and duration, the procedure(s) involved; recruitment details and the nature of the information to be gathered; the gaining of permissions, consent and assent; the means of providing privacy, anonymity and confidentiality of data; data management, storage and use; risks and benefits of the research; and any conflicts of interest.

When the study proposal was written to the supervisor's satisfaction, Ethical approval was granted by the Research Projects and Ethics Review Committee (RPERC) of the Psychology Department of Rhodes University and the Rhodes University Ethical Standards Committee (RUESC: 2020-1305-3576). The approval letter is found in the appendices (Appendix A). The University of Oxford (2021) explains that informed consent is a fundamental principle of research ethics. Its purpose is to make human participants aware they are freely participating with complete knowledge about what it means to participate and consent before entering the research. Participants in this study were well informed about the content of the study and what was expected from them, as they were given information about the study (see Appendix B). After this, the participants were also given informed consent forms (see Appendix C), stipulating that coercion was not present at the time of participation. They were welcomed to drop out of the study when they chose to do so.

Orb et al. (2000) explain that the challenges that many qualitative researchers encounter could be minimised using well-established ethical principles, specifically autonomy, beneficence, and justice. Autonomy in the research study is applied by requiring participants to sign the following documents: the confidentiality agreement

between the student researcher and participant and the permission to use tape recordings form (see Appendix D). With the principle of beneficence, the potential benefits of the study were judged by the ethics committee to outweigh the potential risks.

According to Orb et al. (2000), the other ethical principle closely linked with research is benevolence, and this includes doing good to others and preventing harm. Due to the researcher's interest in the experiences of traditional healers, this involved them talking about their clients' cases. The participants risked providing details of their work with clients. The researcher's aim was not to divulge any personal information disclosed. The researcher always consulted with her supervisor regarding potential risks encountered during the project activity. Participants' contributions are valued for the potential to increase insight to people interested in the phenomenon through hopes to publish aspects of the study once the examination process has been completed.

## 3.5 Data collection

The data was collected using semi-structured interviews. The questions in the schedule were translated into a language that participants were comfortable with (either English or IsiXhosa, because the researcher is fluent in both languages). The interviews were audio-recorded, while the researcher also took notes and observed the non-verbal communication of participants.

According to Pietkiewicz and Smith (2014), semi-structured interviews allow the researcher and the participant to engage in a dialogue in real-time. It also gives enough space and flexibility for original and unexpected issues to arise, which the researcher may investigate in more detail by probing further. This enabled the researcher to gain a deeper understanding of the conceptualisations of traditional healers. Probing skills developed during training were needed to gather complete data.

### 3.5.1 Recruitment and Selection

Smith et al. (2009) state that since IPA is an idiographic approach concerned with understanding particular phenomena in particular contexts, the sample size in IPA studies

is kept relatively small. This is because the transcription of the data collected is time-consuming and requires an in-depth understanding. The sample size was chosen according to the IPA approach. Smith et al. (2009) indicate that the sample size should be kept between 3-6; this provides sufficient cases for the process of identifying points of similarity and difference between participants but keeping the volume of data small enough so as not to overwhelm the researcher with a large amount of data. The initial target was 4-6 traditional healers in and around Makhanda. The participants were all traditional healers who had been practising for longer than two years and were older than 20 years. These participants were selected from the target population, and non-probability snowball sampling was utilised. Wellman et al. (2005) report that non-probability sampling is defined as a process in which the researcher selects a sample based on the researcher's biased judgment rather than random selection. Babbie (2007) explains that snowball sampling is a non-probability sampling in which the researcher is referred to other people by the participants. The researcher contacted two traditional healers that she knew, and these people subsequently made recommendations of the other traditional healers.

The next phase was to contact the people who had made the recommendations to alert them of the purpose of the study and to ask for further details of potential participants. The researcher contacted three recommended participants. One, I was informed had moved to another country and was referred to another potential participant. Two were willing to participate in the study, whilst one explained that her experiences were solely based on people with a calling and had nothing to do with healing people with mental distress. When asked to recommend someone that they knew might be dealing with such clients, the participant indicated that she knew no one in that category. Some potential participants dropped out of the study because they did not have the time. Others no longer wanted to be part of the study. Again the researcher had to find possible participants, refocusing on the search. Certain people that the researcher knew recommended well-known traditional healers. Four participants were recommended to the researcher, but others dropped out. The researcher noted that those who dropped out were all participants with very little or no educational background, and this was quite interesting

to observe. The participants who participated all had more extensive educational backgrounds. One of the participants was discovered through social media, as his Facebook page came up while searching. The participants contacted were from Gqeberha, Makhanda, Dimbaza and East London. The reason for this choice is that the researcher had access to these towns and, in this way, was familiar with the surroundings, making it easier to work on building rapport with the people.

### 3.5.2 Participant Preparation for the interviews

The participants were given the information sheet and the consent forms (see Appendix B and C) a day or two before the actual interview to read and sign. The participants were also asked to consent to the audio recordings (see Appendix D). The interviews were conducted a day after the participants had signed the informed consent. Some participants were not fortunate enough to have access to WiFi and printers and could not send or receive their documents. They were thus audio-recorded, consenting to be part of the study in such cases.

Baloyi and Ramose (2016) state that Africans need to reflect on their experiences. It is crucial to demystify how these traditional healers make sense of mental distress from their perspectives. Bracketing is a method used by some researchers to counter the potentially harmful effects of unrecognised presumptions related to the research and to increase the rigour of the project. Given that sometimes a close relationship between the researcher and the research topic may precede and develop during qualitative research, bracketing is also a method to protect the researcher from the increasing effects of examining emotionally challenging material (Tufford & Newman, 2010). Before collecting data, I met with the supervisor to discuss my own reflections on the phenomena. Certain things were observed, and one of these was the misconceptions I had about traditional healing and what traditional healers thought about mental health. During the process of collecting data, I did my best to eliminate these presumptions.

### 3.5.3 Telephonic interviews

The study made use of telephonic or Zoom video interviews as a way of collecting qualitative data. This was based on the COVID 19 pandemic and the participants' preferences. Opdenakker (2006) highlights that telephone interviews assist researchers in reaching a wider geographical population that might not be possible to access in face-to-face interviews. Contact interactions were limited and risky with the global pandemic, and telephone interviews were felt to be similar to face-to-face interviews.

Cachia and Millward (2011) argue that telephonic interviews are no better or worse than those conducted face-to-face and that they are an appropriate method for collecting sensitive information. Welman et al. (2005) indicate that the only limitation to telephone interviews is that the participants may be skeptical of answering the questions, because they do not know the person on the other side of the line. As the researcher, I was aware of this and intended to establish rapport before the actual interviews. With some of the participants, this was experienced, and the introductory calls made it easier to build later rapport. In addition, it helped to identify the relationship between the person who referred me to the participants and the participants.

### 3.5.4 Audio recordings

Before the interviews occurred, the participants were asked to consent to record the information provided without disclosing any information about their clients (see appendix D). Tessier (2012) reports that interviews conducted in a qualitative setting can be recorded through field notes only, a recording device, or both. The study used the recording device accompanied by notes written by the researcher. These notes (i.e. field notes) were based on what the researcher observed during the interview. Since the interviews were conducted telephonically, the researcher was looking out for the verbal cues and silent moments as they occurred. These included what the participants said during the interviews and verbal cues such as heavy sighs and emotional expressions that might be observed when talking about the uncomfortable topics.

DiCicco-Bloom and Crabtree (2006) highlight the challenges researchers face when recording their interviews with participants. One of these challenges includes confidential information ending up in the wrong hands. The researcher deleted all that information as soon as the write-up was completed to prevent this from occurring. Another challenge is the technical issues where a researcher has to be aware of the room they are interviewing in, to prevent outside noise from masking some of the information provided by the participants. The researcher used an office to avoid any disturbance and avoid external noise. The audio recordings that were taken from the interviews were then transcribed.

### 3.1 Data transcription

Transcribing data is not straightforward, because the transcriber is the intermediary between the heard talk and what gets typed up as text. For IPA, it is more typical to use the sort of transcription that a play would be written in, called “playscript” or “orthographic” transcription (Gibson & Sullivan, 2018), because one is focused on the rather than the linguistic elements. Transcribing tape-recorded interviews into text can be complicated if not done correctly. It has its issues that could potentially interfere with the accuracy of the transcribed data.

Hence DiCiccio- Bloom and Crabtree (2006) report that mistaking words or phrases could lead to a whole different meaning than what was said by the participant. This study's transcription included first listening to the audio while transcribing the data, as suggested by DiCiccio-Bloom and Crabtree (2006). Once that was done, the data was then translated from isiXhosa to English, based on the participant’s preferred language medium. The researcher did this by translating the data herself and then running through the translated data using the google translate app. This app translates from one language to the other, helped confirm the researcher's accuracy in translating isiXhosa to English.

## 3.6 Data Analysis

The study made use of IPA to analyse the data collected. IPA has seven stages that one has to follow when analysing the data. Smith et al. (2009, p. 72) describe several

aspects of the data analysing process. Steps 1 to 4 concern one case before moving to the next.

- Step 1: Reading and re-reading

The first step in IPA is all about immersing yourself in the original data collected. This step is involved with the reading and the re-reading of the data case by case. In the case of transcripts, the researcher listened to the interview recordings whilst reading. Smith et al. (2009) note that this purpose is to place the participant as the focus of the analysis. In reading and re-reading, the researcher aimed to familiarise herself with the text and reconnect to any important themes she had noticed.

- Step 2: Initial noting

The second step was connecting the themes. When analysing data, the themes need to be grouped into different categories that will help answer the research questions. Smith et al. (2009) remark that this initial step is detailed and time-consuming. They further explain that this step looks at the semantic content and language used on an exploratory level. The aim at this stage was to produce detailed notes that help reconnect the identified themes.

- Step 3: Developing emergent themes

Smith et al. (2009) highlight that at this stage, the aim is not only for the analyst to be familiar with the content but also to develop additional essential notes. This data immersion informed the next analysis step by looking at the emergent themes. The analyst's role is to reduce the data collected by grouping it into those identified themes.

- Step 4: Searching for connections across emergent themes

Smith et al. (2009) indicate that the next phase was to order the emerging themes in chronological order. The themes were mapped according to the way analysts saw them fitting together. It is essential to note that not all themes were incorporated. The analyst was therefore required to continue immersing themselves in the data.

- Step 5: Moving to the next case

Once all had been done, the next thing was to move on to the following case. Since the study had a sample of 5 participants, after the first case had been categorized into the emergent themes, I started with the following case and repeated the process. Smith et al. (2009) note that the most important thing to do at this phase is to treat each case distinctively and formulate themes specific to each.

- Step 6: Looking for patterns across cases

According to Smith et al. (2009), this step looked for patterns across all cases, finding the connection between the different instances. This means there was reconfiguration and re-adjustment in this phase.

- Step 7: Taking interpretations to deeper levels

Finding metaphors that can be relatable to the analysis and theories that support the stance of the analysis (Smith et al., 2009). The writing follows the final stage up stage, which involves translating the themes into a narrative account. These themes should be linked up to answer the research questions.

## 3.7 Trustworthiness

A quantitative research study measures three standards for measuring whether research holds: reliability, validity, and generalizability. Golafshani (2003) stipulates that reliability and validity have their foundations in the positivist perspective and should be redefined in a naturalistic approach. Qualitative researchers question the relevance of reliability, validity and generalizability in a qualitative approach. According to Ponelis (2015), several qualitative researchers are comfortable using the same terminology used in quantitative research. In contrast, others prefer to use alternative language to better reflect the different nature of qualitative research. Dependability (reliability), credibility (validity), confirmability (objectivity), and transferability (generalizability) are often preferred. Amankwaa (2006) comments that these are known as Lincoln and Guba's principles for evaluating trustworthiness in qualitative research.

Bloomberg and Volpe (as cited in Ponelis 2015) clarify that credibility refers to how well the researcher's portrayal matches the participant's perceptions. Credibility is about how well the research study measures what it is supposed to measure. Johnson and Rasulova (2017) explain that credibility can be argued to be the same as internal validity in quantitative research. Research is seen as credible when the researcher has confidence in the accuracy of the findings concerning the subjects and the context where it was conducted. Lincoln and Guba (cited in Amankwaa, 2016) explain that the inquiry audit technique achieves dependability. Amankwaa (2016) notes that this is done by having an external researcher (someone not involved in the research process) examine the research process and the product of the study. In this study, this was assured by the supervisor's overview. The purpose of this is to provide evidence that the research findings are consistent. This could be seen as reliability in a positivist approach.

Johnson and Rasulova (2017) explain that confirmability is achieved when the interpretation of data is as accessible as possible from the researcher's personal bias. The study aimed to ensure a degree of neutrality and not allow preferences to get in the way of the study by the reflective "bracketing" process employed at the beginning, where the researcher made her thoughts about the topic explicit. Ponelis (2015) states that transferability is related to external validity or generalisability. Transferability is when the research findings are sufficiently similar to another context. The researcher should describe the results in a way that lets the reader decide whether those meanings are transferrable to their context or not (Baxter & Eyles, 1997). The researcher needs to provide detailed descriptive information. The details should enable the reader to apply the findings to their settings.

## 3.8 Conclusion

The study is based on an exploratory qualitative method. This chapter focuses on collecting data using IPA. IPA is about finding meaning in the phenomenon being studied. IPA aims to discover how people make sense of their lived experiences. The data was collected through semi-structured telephonic interviews and subsequently analysed to produce the findings elucidated in the following chapter.

# CHAPTER FOUR: FINDINGS

## 4.1 Introduction

The chapter concentrates on two parts: the first part describes the participants interviewed. The second part reports the findings of the data collection process, identifying the emerging themes from the research process. The researcher interviewed five participants, who all had previous work experience other than being traditional healers. The participants in the study were all traditional health healers based in the Eastern Cape Province.

Traditional healers from Makhanda, Gqeberha, Qonce/Dimbaza and East London were recruited. They were well suited to provide the information needed for this study since they were each deeply involved in the cultural practices related to healthcare and, in particular traditional healing.

**Table 1 The demographic background of the participants**

| Age | Gender | Place of origin | Education | Previous work | current work |
|---|---|---|---|---|---|
| **PA 64** | **Female** | **Dimbaza** | **Diploma** | **Teacher** | **Diviner** |
| **PB 52** | **Male** | **Makhanda** | **Masters** | **---** | **Manager** |
| **PC 63** | **Female** | **Gqeberha** | **PhD** | **Teacher** | **Lecturer** |
| **PD 45** | **Male** | **East London** | **Diploma** | **---** | **Manager** |
| **PE 65** | **Female** | **Dimbaza** | **certificate** | **Teacher** | **Diviner** |

### 4.1.1 Participant A

PA was 64 years old, at the time of interviewing. The participant reported that she was a retired teacher and had obtained two diplomas. The first diploma was a National Professional Diploma in Education (NPDE), and then a diploma in Advanced Education. She is based in Dimbaza, near King Williams Town (known as Qonce). PA became a traditional healer because of an illness in which she experienced heart palpitations that

were unexplainable to Western medicine. She tried different doctors, but nothing seemed to help her. Someone suggested that she sees a traditional healer who might help her. When she went to see the healer, she was informed that she had a divine calling. The participant trained between 1992 and 1998, when she graduated and became a fully-fledged healer with private rooms. She was confined in a small hut away from other people when she started her training. This took place in her trainer's home, an experienced traditional healer. The process involved a lot of dreaming, where she would have odd dreams that would not make sense to her, but she repeated them to her trainer. She would dream of the process that she was embarking on and her trainer would explain what the dreams meant.

### 4.1.2 Participant B

PB was 52 years old, at the time of interviewing. He is a provincial manager of a publishing company. The participant explained that his highest educational qualification was a master's degree in Education. The participant was born and raised in Makhanda and still resides there, even though he is primarily based in East London. He is a traditional healer, specifically known as a diviner. The participant started displaying signs of traditional calling in High School. He occasionally got sick when he was doing his Grade 8. The participant reported that he saw things that did not make sense to him, but they did make sense to those aware of what was going on. He would see wild animals, and when he wanted to tell people in his family, he became mute. Many other apparent symptoms caused his family to accept that this was his calling. He was taken to a traditional healer and accepted his calling as a diviner, and the healing process began for him.

### 4.1.3 Participant C

At the time of interviewing, PC was 63. She has a PhD in religious studies and resides in Gqeberha. She taught at secondary school before pursuing her divine calling and following her interest in religious studies. The participant reported that she became involved in traditional healing because of her ill health, which was deteriorating. When she started working as a teacher, she became sick often, and her sickness she described

as very odd. She could not walk nor understand what was going on, which was embarrassing. To add to this, she also would experience uncontrollable bouts of menstrual periods, and she sought medical assistance, but the treatments did not appear to be helping. According to the participant, the doctors performed numerous tests to rule out any possible causes, but no pathology was detected. This left the medical professionals perplexed as they did not know what was wrong with her. She sought help from a traditional healer who intuited what was going on and what needed to be done. The person told her she needed to perform a ceremony and start training as a traditional healer. Her condition changed for the better, and she was healed.

### 4.1.4 Participant D

PD is a 45-year-old male divine healer from East London. Apart from divination, he is the Eastern Cape Traditional Health Practitioners forum chairperson. He is also a founder of an institute of traditional healing and a traditional media company. Currently, he is registered at the University of Fort Hare doing Public Administration. He has a diploma in Labour Law, a higher certificate in Monitoring and Evaluation, Management, Project Management. PD has been in practice for over 15 years, offering traditional healing services face-to-face and virtually. He also mentors novice healers in training. He comes from a lineage of traditional healers. His grandmother and mother were traditional healers, and there were also influences from the paternal side. He was 16 years old when he felt the calling to be a traditional healer. At that age, he used to be sickly until the family took action. However, he did not accept it immediately because he had to complete school. The participant experienced bouts of unexplainable dreams about sea creatures and living in the sea. He also experienced headaches that could not be explained in medical terms, and he isolated himself from others. These were all the symptoms that he could recall during the period he was being called. A process of pleading with the ancestors took place, and the participant was only initiated once he passed matric and accepted the call. Another senior healer mentored the participant until he was thoroughly initiated in 2006. After that, he never experienced further sickness.

### 4.1.5 Participant E

PE is a 65-year-old retired teacher. She has a teacher's certificate for Senior Primary School. Like the others, the participant became a traditional healer through ill-health. She was a sickly child growing up. The participant experienced bouts of headaches, which she further explained was a common symptom of the traditional healer and skin conditions. She described these headaches more like mental breakdowns rather than psychotic episodes. According to the family elders, this indicated something more significant than displayed. To them, it was a sign of destiny, only chosen for a selected few. Information about location, training and how long she has been in practice were not disclosed. But she reported that after accepting the call, she never became sick again.

To summarise, each participant is currently practising independently as a traditional healer. They have varied educational backgrounds, from certificates to a PhD, with two having studied to postgraduate level. Three participants were females and two males, all above 40 years. The participants seemed to have been working in other professions before accepting the calling of being a diviner. They have different lengths of practice independently as traditional healers, between 8 to 20 plus years. All participants became traditional healers because of ill health and were trained by senior traditional healers.

## 4.2 Ukuthwasa/ Intwaso (The call)

The following sections outline the responses provided in the interviews. These participants shared their stories on their experiences as traditional healers and the meaning made of mental distress. The narratives included the participants' professional opinions. Before turning to the healers' descriptions of their work with others, it is noteworthy that each provided graphic and detailed narratives of their callings. Key features of these are illustrated below.

### 4.2.1 Participants' accounts of their call

All the participants each told their personal stories about what made them decide to pursue a career in the profession. According to most participants, this was not a choice they wanted to follow, but it was a career they had to pursue due to circumstances. Some

signs also confirmed that this was a career that they needed. For some, family members had to intervene in the process. Ill health, amongst other things mentioned below, was one of the apparent signs of a deeper meaning related to their sicknesses.

a) Ill-health

Before the participants accepted the call to be traditional healers, they experienced odd signs. They were all sick, often with some sickness that could not be explained in medical terms. They all tried numerous regular treatments, leaving them feeling more pain, or being undiagnosed or given the wrong diagnosis. This prompted them to try other means as Western medicine proved ineffective. This often included interventions of a third party suggesting that they try the traditional route. They were told that they had a calling, and the sickness would only stop once the calling was accepted. Once they accepted and a traditional custom was performed, they became better. An example of this follows:

> *Yes, I started experiencing palpitations in 1992. I would get these, and it would feel like something terrible is about to happen. I approached several medical doctors, but there was no change, until I went to see a traditional healer. After the whole process, I was fine again. I have never experienced heart palpitations since then.* [PA]

For each participant, this was not very clear and not something familiar. For some, including PC, speaking up was embarrassing. PC narrates how she got into this profession below, including her relatives' role in assisting.

> *I was unable to stay at work because of menstruation. This lady asked me what was wrong with me. She told me to tell my parents. I was still a young lady and did not have enough information. My uncle was the one who helped me, because he stayed close to where I was staying. I slept at his place, and they did what we call ukungxola (humble submission of guilt for ritual not performed and a promise to perform it at a later stage). To be honest, I did not want to sleep in my uncle's place as I was embarrassed,*

For PD, disturbing dreams about the animals and being in water troubled him to the point that he was petrified. These dreams affected his day to day activities as he experienced headaches and lost a lot of weight.

*And then I had endless periods of experiencing headaches. I would drink pills and headache powders, but nothing helped. Nothing would help at the end of the day. Uh (stammering), I ended up losing weight, became thin, and people even thought maybe there was some sickness that was affecting my body.*

The above examples all illustrate different ways in which ill-health, often seemingly not responsive to standard medical treatment, signalled to those who were wise that the individual needed to seek the traditional healers' advice and to be responsive.

b) Change in behaviour

The calling reported changes in how people behave; one of the participants even reported certain things he could not do during the process of being called. He could not speak when he tried to describe what had been revealed to him.

*The divine calling can make people behave in different ways. It started when I was still a student. I was in high school when I got sick and probably did Grade 8. I could see things that did not make sense to me, but they did to those aware of what was going on. I would see wild animals, and when I wanted to tell people in my family, I became mute. I could not speak. There were other symptoms that the older people in my family picked up upon before this, but the main thing that happened and caused my family to accept this was that I suddenly could not speak. After consulting and deliberating with what was already revealed to them, the family decided to accept my calling. They gave up on denying me the calling of being a diviner, and I was taken to an experienced diviner, according to culture, to be healed. I went and accepted the calling and the isiXhosa procedure began for me.* [PB]

One participant reported that this calling could sometimes be embarrassing for the person going through all this, as it does not make any sense to the person and is not viewed as normal and acceptable.

*When I was teaching, I started experiencing strange sicknesses. My colleagues knew about my episodes. It would sometimes be seasonal when I find myself unable to walk. Sometimes I would joke about it with colleagues, especially when I feel better. I would go to work and make jokes about my inability to walk. I would be bored at home and would often go back to work. Some people thought I was disabled because I was unable to walk. It was not explainable what the cause of this was. I would also have other sicknesses. I*

*would also menstruate uncontrollably. I would go to the doctor, and they would test if I had fibroids but would not see anything wrong.* [PC]

In addition, both PD and PE illustrate that this calling can start at a young age. The calling does not wait until the person has matured or become an adult. The participants were in their teenage years and could not understand what was happening. For example, for PD

*The calling started being apparent when I was 16 years old. Um (pause). When I was 16, the calling was clear. I got sick, so sick... Oh, another symptom that I had was related to chest problems. I would experience bouts of shortness of breath, as if I was an asthmatic person. Oh, another thing that I forgot to mention was how I would experience sore teeth. My teeth used to be so painful. As a result, I removed most of my teeth due to the pain. I would remove one tooth, and another would start to be painful.* [PD]

Then for PE, this extract below indicates that the childhood of the healer was affected, as she spent a lot of time in hospitals as she was sick.

*It was through my health. I was never a person who suffered from any mental disturbance. It came through physiologically, as I started at a very young age. Throughout my childhood, I was very sick. I was in and out of hospitals, you see?* [PE]

Although some may have had family members go through the divine call based on all these extracts, the traditional call. Each case is unique and personal to the narrator. All the participants highlighted that they experienced sickness or strange physical manifestations, which was the first indication of the call. Behaviour change is also noted as another sign of traditional call.

c) Inherited gift

For some, though, this was harder to accept as they knew nothing of this line of work. Whilst some of the participants grew up in families where this line of work was passed down from generation to generation. This made it easier for them to accept the call and move on with their lives. This is important to note, as some participants come from a bloodline of healers, enabling them to confirm their call. Three of the five participants had a family member(s) who were also divine healers.

*My father was a traditionalist, and my mother was a…, you know, a nominal Christian.* [PC]

Some of the things they were exposed to were familiar to them, however, they were the first to be fully-fledged traditional healers, making it a significant achievement for the family.

> *Firstly, I come from a family of traditional healers. My grandmother was a traditional healer, my mom, and my father's side. I am from a family of people who were traditional healers. Even though some were never initiated formally, they are spiritually gifted in many ways. So I have that family background.* [PD]

PE illustrates that being a fully-fledged traditional healer with all the accolades is a noteworthy accomplishment for a healer.

> *I was the first to receive itshoba (oxtail, which is a sign that your training is completed), that I have completed the training. Others before me have gone through the training, but have not completed the training*. [PE]

This calling can sometimes be passed from one generation to the next. However, each story is different from the next. Each person is called in their own unique way.

d) Unusual dreams

Two of the five participants reported that they experienced a lot of weird dreams. Both PC and PD explain that these dreams were strange and could not be explained.

> *When I was teaching, I experienced a lot of strange dreams. I would narrate the dreams to my parents, but they would not say anything. [PC]*

PD goes into detail about the content of these dreams. These dreams were more of an instruction guiding him to where he needed to be.

> *As for me, I had dreams that I could not explain. Some of these dreams were scary, uh I would dream of animals. I would dream of mhm living underwater. Furthermore, I would dream of being dressed up in animal skin uh. I would mostly dream that, um, I was at a place where there was a sea. So it was such dreams errr, which at times left me feeling scared. [PD]*

To summarise, it is essential that as part of their meaning-making, each participant narrated how they got into this line of work, including being ill, change in behaviour, inherited gifts, and unusual dreams. This emphasizes the primacy of a spiritual element in the ways in which they construct their work. All the participants reported that their first sign was their health being affected. It seems this is the way ancestors speak and capture

one's attention. Each story is unique as the illnesses are manifested in different ways to different people. Two of the participants report that they were called at a young age, which affected their childhood as they were examined continuously, looking at what might have caused it.

## 4.3 Defining mental distress

This next section focuses on how traditional healers make sense of mental distress. This section seeks to answer the research question about their conceptualisations of mental distress and what they think causes mental distress. These are based on their experiences with dealing with clients displaying symptoms of mental distress.

### 4.3.1 Aspects of identifying mental distress

The participants described many aspects of mental distress, including behaviour change, clothing choices, and speech changes. These all appear to indicate whether a person is mentally distressed or not.

### 4.1.2 Behaviour change

All five participants reported that behaviour change is the first sign that determines if a person is mentally distressed or not. According to the participants, a person acting outside the expected norms is likely to show signs of being mentally distressed.

> *Their behaviour has changed, they are rude, their appetite changes and they start eating like animals*. *Some usually get lost or fight with others, or they destroy things. (Pause) Some are just aimless wanderers, or they disappear* [PA].

This illustrates how behaviour changes, where others notice alterations in what is typically expected. The emotional impact of these is also indicated as it is reported that some constantly fight with others, and others wander off to where no one knows about their whereabouts. This is also mentioned in the following excerpt.

> *Something that will assist is to look at the behaviour of the person. Certain behaviours stand out in clients. If something has to do with family customs, some behaviours stand out to you as the person is engaging with you. Whether they are aggressive or not, some*

*even dress well and are bright and may even act normal, but it may be that they are mentally distressed*. [PB].

The diversity of behaviour changes is illustrated above, although PB also noted that the person might feel distressed, even though there has been no visible change in behaviour. The other participants expand as follows.

*A symptom will tell you what is wrong with the person. For example, I once had a client who, while at work, started rolling up his trousers and started dancing with a traditional rhythm, and he was dancing to a traditional song.* [PC]

So looking at the person's behaviour will indicate what the diagnosis is. The following extract illustrates how the person's behaviour indicates mental distress.

*Some are reported as violent and break things in their homes.* [PD]

PE reported that she intuits the distress related to violent actions or visions:

*You only notice a person with divine calling acting violently by describing what they see that others cannot see.* [PE]

The above examples expand on the variations of behaviour change that may be observed, with some reported by others or noticed in the consulting room.

### **4.2.2** Speech change

Four of the five participants understood mental distress as presented through speech disturbance. A person's distorted speech can be something that does not make sense, alerting the healer to possible mental distress. Examples from three participants below illustrate this aspect.

*They disappear, whilst others may have disoriented speech.* [PA]

The participants report that a speech disturbance can also indicate the disturbances.

*The person's speech will alert you to the problem.* [PB]

Meanwhile, PD illustrates that the person might adopt to a foreign language that others may not know.

*When we ask him, he replies to stuff that is not relevant. Some may even speak in foreign languages, which others cannot understand.* [PD]

In the following extract, PE reports that speech disturbances for someone with a calling differ from those with mental distress.

*The person who has a calling will not speak the same way as a mentally disturbed person, and you can even tell by the disoriented dialogue.*[PE]

PE thus distinguishes the signs of a calling from other forms of mental distress. Again these symptoms may be noted by the healer or from reports by others.

### 4.3.2 External processes

When the participants were asked what they thought the cause of mental distress was, they alluded to many factors that may have caused it. According to the participants, there is no single cause of mental distress, but different factors contribute, as described below.

- Supernatural factors
  a) *Isiko* (traditional customs)

The participants indicated that traditional customs are the most prevalent cause of mental distress, and neglecting to perform customs that one is required to perform has profound repercussions. Participant A highlights the importance of having these customs performed, including giving an example related to a child born to unmarried parents:

*It may happen that some never had isiko (traditional custom) done for them. Do you understand what I am saying to you? The traditional custom was never done, and this person needs that to take place. For another, at times, they may be born out of wedlock. The person has had the traditional custom done only from the mother's side, but they need to consult with their paternal family and have these customs performed from that side. The paternal ancestors could cause them to appear as if they are mad. And once the custom is done, the person is alright.*

The following is an extract from participant C, also indicating the consequences of not having a custom done.

*There are many reasons why people get sick. Yes, there are instances whereby you get sick because there is a custom one needs to follow. For someone like you, who is not a drunk or at the age you are at and well, and you wake up and have wet your bed, that to us means something. There is a custom that needs to be conducted on your behalf. We will not look at your sphincter muscles because they make sense; why would it be loose? In psychology, you would say something is frustrating the person. The question then*

*becomes, what could hinder a 7-year-old that never wet himself and all of a sudden does? So we believe that there is a reason for this, so I say we look for symptoms.*

The above examples illustrate the important role accorded by some of the healers to traditional customs that are culturally expected in various circumstances.

b) The role of ancestors

To add to this, the participants also included that these traditional customs are a form of communicating with ancestral beings. This was raised as an issue that causes mental distress. Failing to listen to instructions from the ancestors is viewed as taboo, potentially leading to dire consequences.

*A certain percentage of clients I have observed are mentally distressed because of the divine calling. This is a more straightforward process, as I have observed that once we have been through the observation phase. We take the person to consult with their ancestors* [PB].

PB thus states that it is easier to deal with mental distress caused by the divine calling because the next steps to take are clearer. PD argues that mental distress does not just happen. Minor signs are revealed to the person and those around. If no attention is given to these, they become more intense, leading to mental distress.

*You do not just become mentally disturbed, but minor signs keep presenting themselves. Nothing is done to deal with them, especially for families that do not believe in our cultural beliefs. When these signs are ignored, mental distress tends to be severe.* [PD]

So according to the above, being ignorant of cultural beliefs and values can exacerbate or cause mental distress. This illustrates a potential clash between traditional beliefs and other meaning systems, which may then present as cognitive or emotional disturbances.

c) Jealousy and witchcraft

In addition to participants seemingly all agreeing with the above potential causes of distress, additional causes were also mentioned. Two of the five participants reported that another cause of mental distress is jealousy and witchcraft performed by other people. This appears to be related to families who seem to have done well economically.

*The thing about jealousy is that others could see a particular family that appears to be progressive. The parents can provide for their children, which can cause others to use*

*witchcraft on the children of the progressive parents because they have not succeeded in causing harm to the parents.* [PA]

PA therefore alludes to envy leading to negative uses of traditional spiritual powers.

PB also adds that revenge can be the cause of mental distress.

*I also don't want to disregard what I mentioned earlier about revenge and witchcraft.* [PB]

This means that if one has wronged another, the person can cast a spell intend to cause the person to be in a state of mental distress. These examples thus move beyond the realm of traditional and possible ancestral influences, to include interpersonal conflict.

- Physical factors

a) Substance Abuse

Further possible causes were reported by two of the participants who indicated that substance abuse could cause mental distress for the youth in the country. For example, PA said briefly

*Let's not mention the drug issue. Others may always be intoxicated with alcohol.* [PA]

PB claims that the youth can be mentally distressed because of the abuse of substances.

*I will say this, with our youth, I notice that the majority of times, it's the abuse of substances. The parents are not even aware of this, and their only concern is their mentally distressed child. They only observe what is presented. I notice this a lot, and I usually request to speak to the parents or the family alone and give them advice on where they should go after this.* [PB]

These participants acknowledge that substance abuse affects youth and has potential consequences for their mental health. Above PB seemed to indicate some sort of referral onwards for assistance.

- Psycho-social factors

a) Family conflicts

Family-related issues were highlighted as another cause of mental distress.

*Things such as family disputes can contribute to the client's distress.* [PB]

PB and PE highlight that disputes amongst family members affect mental health.

*Yes, people can be mentally disturbed because of family issues.* [PE]

Both of these participants thus highlight conflicts in families as a cause of mental distress, but further details were not provided.

b) Being at a wrong place

One of the five participants highlighted that seeing things that one is not supposed to see could also affect mental health.

> *It may happen that the disturbed person was visiting and entered a room that they were not supposed to enter, and they probably saw what they were not supposed to see. It could be that they saw this huge snake that the owners hid. We don't normally see such things. This causes one to have permanent mental damage, leaving the person institutionalised.* [PE]

The above example illustrates a seeming blurring of reality with imaginary worlds, but with negative consequences for the person involved. They described mental distress to be caused by things that are outside of the individual stimuli. This indicates that the systems around the individual cause mental distress.

c) Psychological problems

Only one participant out of the five perceived psychological problems as the cause of people's mental distress. For others, mental distress is caused by things that we would locate as outside of a person's psyche. The following extract is taken from PA;

> *Others can be mad because of the problems that they have. What is referred to as depression in English? You see that the person's problems are too much, and the person is not happy. They are not sleeping due to debts and more debts, causing the person to have disoriented speech and appear crazy.*

Only one participant viewed possible internal cognitive processes as the cause of mental distress, mentioning the term depression. However, even this seemed to be linked to material worries. The majority therefore, understood mental distress as caused by external processes that are not related to an individual's thought or emotional processes.

## 4.4 Healing from an African context

The following section focuses on the methods and processes of healing that traditional healers use to treat mental distress. It looks at how they perceive their work as healing for their clients.

### 4.4.1 Spiritual and mystical influences

Even though the participants seemed to describe their work in similar ways, there were some differences in their job descriptions. Some understood traditional healing as something they were gifted with.

*a)* Divining as a gift

Out of the five participants, three reported that their work included divining. Participants expressed their job as something that only a few can do.

> *I do divination, and I also heal people. I tell people stuff based on what I observed as a presenting problem.[PA]*

PC reported that diviners have diverse gifts, and not all are the same.

> *Diviners are gifted in different areas and are not the same. I want you to know that I am the kind of diviner with the white beading.[PC]*

PC and PD both confirmed that each gift given is different to the other and some used labels specific to their training (such as the mention of “white beading” above, which is a signifier). One might specialise in training novice healers, and the other might be to heal.

> *That is why I said the gifts we are given are not the same. [PD]*

All the participants described this calling as something given to them and not something they attained themselves, and that the individual does not have a choice about which gifts are given. The person accepts whatever gift they are given and apparently cannot exchange or decline the gift.

b) Observation, diagnosis and predicting

Participants are trained in methods of intuiting the problems of the people who arrive for assistance. For example:

*You stay in a house where you will be trained and initiated when you arrive and taught how to diagnose and predict what could be wrong with the person in front of you. [PB]*

PB explains that calling includes being taught to diagnose and predict what is wrong with the person that consults them. PC continues by describing what she looks out for, appearing to dismiss witchcraft as a rationale for what is being experienced.

*That is why I say we are looking at the habits. Sorry I mean the symptoms. You have been doing many things in secret, and now you are being exposed. This has nothing to do with witchcraft. It is your actions, right? It is a punishment for your actions.* [PC]

Observing the client determines what is wrong with them and through experience participants work out how symptoms allow them to diagnose the problem and what has caused it.

c) Communication with ancestors

Before diagnosing and treating, some elaborated that the job description also included constant communication with the ancestral beings, this is the source for direction on how to proceed. This again emphasizes that it is not about individual choices, but rather rooted in guidance from ancestors. For example, PC stated:

*A diviner has to communicate with the spirit beings, and they are in contact with those no longer around.*

This implies the importance of those who have gone before as influencers of the actions of the healers.

d) Training of novice healers

Two of the participants highlighted that their job description included the healing and training of novice healers. Participant B emphasised that he trained novice healers who are in the process of graduating to be healers who practice independently. So his work is about training young healers to diagnose and treat people. He continued onwards from the quote above in b) as follows:

*I practice as a healer, um I run services for spiritual healing, including traditional healing as part of the services that I-I am offering.*[PB]

This implies the importance of those who have gone before as influencers of the actions of the healers.

e) Advising and treating

One of the participants included that his work also included advising his clients, and that the client makes the decision.

> *So you advise the person based on what they have told you, or the person comes to you in a clean slate, sitting in front of you and expecting you almost to predict what is wrong with them. You check and predict and say what is wrong. This helps and makes it easier to know what the person needs because you have checked and investigated what is wrong.*[PB]

The above section again emphasizes the primacy of the spiritual realm in the work of traditional healers. They emphasise that what they do is a gift, although they also experience the influences of their training in observing, diagnosing and treating (as noted in the final excerpt above).

### 4.4.2 Methods of treatment

When participants mentioned different methods of treatment, very little was said. Some participants reported that going into detail about their methods of treatment for ailments was something they could not disclose to the researcher. For example, PB said

> *Sandie, I will not mention any medications I prescribe to clients.*

One participant reported that she uses herbs to heal people, and ancestors instruct in the choice of these herbs through dreams.

> *We check a person through using herbs and dreams that the clients narrate. Maybe I could have a vision of the person. For example, treating witchcraft, dreams, herbs, and visions could help the client.* [PA]

Participants seemed to emphasise that they could not prescribe without a thorough examination.

> *When you don't do a thorough examination before prescribing any medication, that could make the clients even sicker.*[PE]

Two of the participants described their jobs involving having dreams and revelations, and some take place when one is asleep or awake. They therefore imply that they see what others may not see.

*So you get a vision or a revelation, or it could be anything whispering to you.* [PC]

PC describes these revelations or visions as something that comes to a person. PE explained that these revelations come to you when you are asleep and both claim that these revelations come or are revealed to one only in secret.

*For us, you sleep, and while sleeping, you see all that has to happen to your client or you. This means,…It does not mean that you have to sleep, sometimes you can have a vision. Those visions could be apparent only to you and not anyone else. The second person might not see this vision that you are seeing. This depends on whether you could see this animal before you, and others might not see it. [PE]*

Different methods are used to assist the traditional healers in doing their job. One of the participants reported that his work includes reading bones and cards to help him get a clear sense of what is wrong with his clients. He explained that his calling is a mixture of “white and red beaded calling”. That is why he does not solely rely on divining but on all other means as well, seemingly being guided in his decisions of what methods to use.

*On top of that bone reading, I also check people through dices or dominos and play cards. So it depends on that particular client in front of me.* [PD]

The traditional healers' dreams and visions that come from the ancestors direct and instruct what treatment should be used for each presenting problem.

### 4.4.3 Attitudes towards western practices

Participants reported that they refer clients to medical doctors if they feel that the problem is something they are not familiar with. The participants highlight that they decide what to do with the client based on the presenting problem. Four of the five participants reported that they refer clients for various reasons, including matters that need a mental health expert, treatment for substances or HIV. Below are the participants' accounts of their reasons for referring;

*I will only answer based on my experiences. In the divination process, it could be revealed to me that the client needs to see a psychiatrist or a psychologist. I would refer them to a*

*mental practitioner. I would be instructed that I must not heal such a person because of their presenting problem, for example, illnesses such as AIDS. I am in no position to tell a person that they have AIDS, and it's not my place. This, though, depends on how educated the diviner is cause some diviners who are not educated and have never gone to school may not know that they are supposed to refer that person to the clinic. We are supposed to work with doctors because we work and heal people based on what we want—for example, working with someone who has ibekelo (a situation where one puts a poisonous trap for another person to walk into). I heal that poison and take it out, but the person might still need an antibiotic to heal the wound. Do you understand? Another case is the issue of HIV, where a person needs to take their treatment. Take, for example, the issue of "ibekelo" I drain the poison out, but the person still needs an antiseptic cream and bandages that I don't have. Sure, I can give them medicine such as umathunga (a traditional medicine to treat internal wounds), to drink to clean the wound internally. It may happen that I would heal the septic wound, but the person still needs to be dressed up in the clinic, and I don't have the necessary equipment required. I don't know anything about stitching up a wound, and that's where health care workers come in. It is crucial to work with medical doctors. [PA]*

The above account illustrates that this healer has a clear sense of the boundaries of practice, what is an appropriate role and the limitations of her training. This seems to illustrate a cooperative working relationship with medical doctors and clinics.

Traditional healers refer their clients when they present with problems that are perceived to be outside their scope of practice. According to PA, HIV/AIDS is something that she cannot play with, as it is something outside of her skills. She also highlights that some traditional healers through scam claims, encourage people with HIV/AIDS, to consult with them and claim to treat it, especially those with no educational background. In the following excerpt, PB reports the difficulties encountered at certain times:

*If it comes to things you have no understanding of, e.g. a person craving substances could be a high indicator of substance abuse. Sandie, I must say that we treat people nowadays at a very challenging time. It is a difficult time that we are healing in. People are very clever; people can disclose their problems in some instances and hide them at other times, which confuses even those close to them. We are treating people at a very difficult time.*

*That is why we always say it is important to refer, so that we all get to participate Uhm…., and offer the services needed by clients. [PB]*

Participant B indicates that referring is essential when it is unclear what the presenting problem is. He reports that certain things might be hidden to the traditional healer, and attempting to treat when all the information is not disclosed is quite tricky and challenging. The following excerpt illustrates the need for caution when using traditional remedies.

*We have had an experience where some healers see that the person is weak and has lost weight, and they gave them our medication. You see, our methods may be too intense for such an individual. They include purging and drinking herbs for loose stool and other things that may be too harsh for someone with a low immune system. [PD]*

Both PD and PE (below) refer to some traditional medicine as brutal and harsh for people who have weak immune systems. PD explains that the medicine may lead the individual purge and have diarrhoea. This could leave the person dehydrated and may impact negatively on the immune system.

PE clarifies further how cautious traditional healers need to be, especially if there might be an HIV diagnosis and refers to having attended courses to assist.

*Firstly, there is HIV that caused such a big fright back then. Many people tend not to pick up HIV as a diagnosis because it can present as a mental disturbance. Some tend to run towards traditional healing, and you will find that they got sick from using traditional medicine. I had about four clients whom I referred to the clinic and hospital. This gentleman came up to me and told me he disapproved of my methods. Maybe the level of Education that I have, or maybe because of the courses I have attended at Cintsa. I attended some courses that informed us about looking at the clients' symptoms. There are symptoms that I refer to the doctor immediately. As soon as I see that the client is fragile, I refer to the doctor. The first thing I do is look at the person's status.* [PE]

These extracts illustrate how the participants refer clients to a variety of health professionals when dealing with issues that they recognize as being beyond their training or where the person's health status seems to require medical interventions. This indicates that a collaboration between the two worlds could provide holistic healing for clients.

## 4.5 Conclusion

The traditional healing methods are diverse and depend on how the traditional healer was trained and the instructions that they believe have been given by the ancestors. From the extracts above, what is important to note is that traditional healing is not just about the healer and the patient. Rather, it is something done as a collaborative venture, seeking to work with others where needed. The healer does not simply rely on skills and knowledge but is guided by different influences in relation to mental distress. In addition, it is important to note that when considering the accounts of participants, mental distress is not about focusing on the internal thought and emotional processes related to what might be considered the psyche. Traditional healers focus on aspects that may influence the psyche, including the external forces that could impact the person. This also includes family, community, and spiritual connectedness.

The findings are divided into three themes to focus on the research questions identified. The first section focused on the perspectives of traditional healers. The second section defines mental distress based on the traditional healers' experiences. Lastly, the study is concerned with healing from the African context. From each of these, sub-themes were noted and explained. The following chapter focuses on the discussion around the three themes and the six sub-themes identified.

# CHAPTER FIVE: DISCUSSION

## 5.1. Introduction

The following chapter presents the study results on conceptualising mental distress from an African Psychology Approach using Interpretative Phenomenological Analysis, views of traditional healers. It is a discussion of the results as described in the previous chapter. The discussion is based on the findings that highlighted the narratives of traditional healers on mental distress. The purpose of this was to make sense of what is understood by traditional healers as mental distress from an African Psychology perspective.

**Table 2 Below is a summary of the emergent themes identified with the subthemes**

| **Main themes** | **Sub-themes** |
|---|---|
| *Ukuthwasa*/ *Intwaso* (the call) | Participants' accounts of their call |
| Defining Mental distress | Aspects of identifying mental distress |
| | External Processes |
| Healing from an African context | Spiritual and mystical influences |
| | Methods of healing |
| | Attitudes towards Western practices |

## 5.2. Ukuthwasa/Intwaso (The call)

The previous chapter illustrates that accepting and receiving the divine calling is experienced in different ways, and it is unique. Each of the participants narrated their story of the process of *ukuthwasa*. Thule (2018) explains that being called to be a healer is experienced as many unexpected twists and turns, and according to her, everything turns upside down. Prior to conducting this study, It was not expected that participants would give such a rich and detailed description of their divine call processes. This helped lay the groundwork for illustrating the work of these healers and their unique profession.

Before the participants commenced with the interviews, they introduced themselves and narrated how they became involved in the traditional healing process.

It was interesting to observe how the individuals introduced themselves, fully stipulating their names, surname, where they come from, and clan names. The clan names were important for indicating how the participants claimed their legitimacy through the spiritual world that accorded them prominence in the community. This illustrated the African spiritual lineage that participants associated with the status of their work. It seemed to carry profound meaning for the participants. Being a traditional healer was not something they woke up and decided to do, but something that was often in the family's lineage. Something ordained for them before they came into existence. Zwane (2020) claims that clan names in themselves carry hidden information, this could include, history, a very long story perhaps about the people of that clan, it could be a story of a long line of Kings, famous people or a whole family. The use of clan names helps keep track of those who are no longer alive but live amongst us. Mkhize (n.d) articulates that African ancestors continue to give Africans a shared and personal sense of self-affirmation, identity and unfettered belonging.

Secondly, the participants highlighted how they became part of the work of healing as traditional healers. They gave in great detail their experiences before accepting the divine call. Again, this demonstrated how their work and the self are inseparable for these participants. Before answering any of the interview questions, this background was crucial. Nwoye (2015b) highlights the importance of the spiritual to Africans.

*Ukuthwasa* was implied in the study as a process in which traditional healers transition from the old life to becoming new people. Mlisa (2009) defines *ukuthwasa* as a unique and spiritual journey for each individual, which embodies nature and the ancestral world. Kubeka (2016) reports that *ukuthwasa* indicates the death of the self and the re-birth of the new. The participants reported that before accepting the call, they went through a phase where they experienced a lot of ailments. Seeking allopathic treatment proved to be ineffective as their conditions worsened. None of the participants seemed to

be aware of what was going on. For the participants, the journey was complicated by confusion and uncertainty.

Mpono (2007) confirms that traditional healers experience symptoms that do not necessarily mean they are ill and cannot be treated with western medicine. Mlisa (2009) adds that this is not a sickness as the west would diagnose it as, but *inkathazo* (trouble), since it involves syndromic illness and a conglomerate of factors that culminate in various afflictions. According to these narratives, none of the participants joyfully accepted the call of being a traditional healer. Although some come from family backgrounds with traditional healers, none appeared to actively choose the career they have taken, but it seemed that the profession chose them. This period is important in the process as Podolecka (2016) reports, many do not choose this vocation but are called. The only way for this calling to occur is through a series of misfortunes, medical and mental emergencies. The participants reported that this included hallucinations, anxiety, pains, loss of speech, and loss of mobility. What was interesting to note was that each participant had a different and unique experience. This experience directed what kind of speciality the healer would be concentrating on.

Ivanescu and Berentzen (2020) claim that shamans are beyond space and time, and they live in mythical dimensions enabling the envisioning of continuous cycles of death and rebirth. Kubeka (2016) claims that participants sacrifice the life that they know, in order to fulfil the wishes of their ancestors. Failing to obey these wishes could cause severe health issues for the individual. In a way, this indicates to the individual to pay attention to their divine duties, but it also familiarises them with communication with metaphysical beings. Mlisa (2009) claims that a “called” person goes through this process of healing the self to heal others. She explains that these healers are seen as “wounded souls”. A conclusion then, is that *ukuthwasa* is a process of transitioning from one realm to another. With this transitioning from one realm to the next, each person has to go through a spiritual journey, as the healers themselves go through the path of needing healing before healing. This is contrary to the Western belief system, even though Jung seems to imply something similar in his theory of wounded healer. Jung’s interpretation

of the wounded healer relied upon believing that all people experience trauma (Newcomb et al., 2015). It is reported that Jung believed professionals would naturally bring this experience into their professional development. Once the participants accept this calling, they go through intense training with the help of a traditional healer and guidance from their ancestors. During this time, the participants perform rituals, and dreams appear as revelations and guide as to what they are expected to do.

To briefly summarise what is highlighted above, African Traditional training of healers has a lot to do with the spirituality of the healer. The individual needs to be connected to the spiritual, mystical realm. The essence of this is so that the healer can be guarded and instructed as they heal and treat others. Baloyi (2008) confirms that one of the tenets of the Afrocentric paradigm is the permable boundaries between the spiritual and the physical realm of human beings. This is not the case for most of psychology's theories. Nwoye (2015b) confirms that Western psychology defines humans only in material, measurable, or observable terms, paying little attention to human religiosity and spirituality, which belong to the invisible realm.

## 5.3. Defining mental distress

The next portion of the chapter focuses on how the participants perceive mental distress. This was done using the subthemes that were identified, including aspects of identifying mental distress and external processes. Laher (2014) points out that non-Western cultures see the self as consisting of three parts, the mind-body-spirit. All three parts of the self interact continuously with each other to maintaa in harmonious balance in the body. Once there is no harmony between mind-body-spirit, the person is likely to encounter illnesses or ailments that require treatment that will bring the balance between the parts. Laher (2014) states that it is vital for practitioners who are trained predominantly on the mind-body duality to adopt the mind-body-spirit continuum that is practised by non-Western cultures.

### 5.3.1 Aspects of identifying mental distress

Based on their experiences in practice, the study considers what participants have identified as mental distress in their practice. The provided subthemes explain how the participants understand mental distress and its causes. According to *Action on Disability within Ethnic Communities* (2003, p. 4), mental distress can be defined as something that affects a person's way being, thinking, feeling and behaving. It includes functional mental conditions such as anxiety, depression, and psychotic conditions such as schizophrenia, bipolar disorder; and it also includes somatic symptoms such as fatigue, stomach-aches, or insomnia.

Participants were asked how they identified a mentally distressed person. The participants highlighted that behaviour change, appearances and speech change are the leading indicators that inform them that their clients are mentally distressed. Behaviour change was the primary indicator of mental distress. Participants highlighted that individuals with mental distress also display signs of emotional disturbances. According to participants, the person tends to be more aggressive than normal. The DSM-5 highlights some of the symptoms mentioned by the participants as symptoms of psychological disorder. DeAngelis (2021) reports that people who suffer from persecutory delusions and command hallucinations tend to think that others are out to get them. Grandiosity, as well as the manic and hypomanic phases of bipolar disorder, can also play a role in violence and aggression. Although DeAngelis argues that mental illness may not always be the cause of violence, one needs to also look at the patient's history, which is vital to note. Research illustrates that there is a relationship between the two aspects. Warning Signs and Risk Factors for Emotional Distress (2021) highlights that the common warning signs of emotional distress include having aches and pains, pulling away from people, thinking of hurting or killing yourself or others. The participants seem to view mental distress and violence as having a casual relationship.

Participants mentioned that another symptom of mental distress is disorganised speech. The participants highlighted that when a person is not making sense in their dialogues with others, this indicates mental distress. Holder and Wayhs (2014) report

delusions, hallucinations, disorganized speech, and disorganized behavior are examples of positive symptoms of schizophrenia. The DSM-5 identifies some of these as symptoms of certain mental disorders. This indicates that what the traditional healers have stated is not different from what Western health practitioners have identified as some mental disorders' symptoms. The next portion of this chapter focuses on the causes of mental distress identified by the participants.

### 5.3.2 External Processes

*Action on Disability within Ethnic Communities* (2003), stipulates that medical doctors believe that mental distress is mainly caused by three factors, although it is difficult to be absolutely certain in all situations. At times people with physical distress can display psychiatric symptoms. These include the following;

- Chemical imbalances in the brain;
- Stress and everyday problems;
- Exposure to severely distressing experiences.

Based on their experiences as practitioners, participants were asked what they viewed as the leading causes of mental distress. Interestingly, the extracts indicate that for traditional healers external processes cause mental distress, and that the person appears to have little control of their mental well-being.

- Supernatural factors

*Isiko* (traditional customs or rituals)

What was noted is that the refusal to follow traditional customs (*amasiko*) can be the leading cause of mental distress. *Isiko* is a cultural practice that is unique to a particular ethnic group. Mndende (2002) explains that *amasiko* involve rites of passage publicly performed as they have spiritual and social implications for the entire clan. She further illustrates that these customs involve sacrifices to mark birth, initiation (of traditional healers), marriage and death. The amaXhosa people perform rituals and ceremonies for several reasons, including asking for guidance from the ancestors, learning the ancestors' wishes, and communicating and appeasing the ancestors. They are a form of therapy for those with *intwaso (*the call*).* These cultural practices have a lot to do with communicating

with the ancestors and connecting with African spirituality. Both culture and spirituality are crucial for the participants, these are seen to contribute to the balance of an individual.

Appeasing the ancestors by following *amasiko* is a way of connecting with them. The participants indicated that these customs guide them to their ordained path. Refusing to follow these customs is a form of neglecting ancestral guidance or refusing to follow instructions. The circumstances of not following the customs could lead to severe consequences. Spiritual disconnection with the ancestors was seen to cause an imbalance in the psyche and well-being of an individual. This is different to how the West perceive the human psyche. As Baloyi (2008) confirms that the West understand the psyche as consisting of "body" and "soul". Nsamenang (2006) states that the African worldview envisions the human lifecycle in three phases, ancestral, spiritual, and social. He further reiterates that ancestors are the living dead, or they are the spiritual presences in the affairs of the living. The ancestors play an essential role in bringing balance to the life of those assigned to guide.

The role of ancestors

The second cause of mental distress identified by the participants builds upon what has been mentioned already. The participants acknowledged the role ancestors play in influencing the psyche of a person. Berg (2003) supports this by saying that the presence of ancestors is the most crucial factor in maintaining good health. Starkowitz (2013) also articulates that traditional healers may refuse allopathic medicine because they believe ancestors are involved in their mental distress. This, as indicated above, is a prevalent way of understanding mental distress. The participants asserted that mental distress occurs when the ancestors instruct a person to follow the path of divine healing and they refuse. They reported that the ancestors would give the person a subtle sign to take up the call, and once those instructions are ignored, more severe mental distress symptoms start appearing. This correlates with Berg (2003) stating that ancestors act as guides or mentors for those living.

The participants mainly reported that ancestors are there to communicate with people when in distress, and once spoken to, the ancestors can fix what is wrong. They referred to ancestors as cosmic beings who control the well-being of humans. Berg (2003) refers to this belief as ancestral reverence. It is the belief that something of the dead person does not entirely perish, but it survives and is given substance in this respect. The ancestors' role was seen as necessary when it comes to the *ithwasa* (initiate) seeking direction for the divine call bestowed upon them and for healing from disturbances that do not make sense. The participants sought the aid of ancestors in their journey as healers.

To conclude, both rituals and the role of ancestors focus on the spiritual aspects of mental distress. Mkhize (2020) confirms that ill-health destabilises this balance and the imbalances require a stimulating process. Nwoye (2015a) reports that the missing dimension in the Eurocentric paradigm of mental distress is the spiritual perspective encompassed in the Afrocentric paradigm and accounting for the origin of particular instances of mental distress. All these scholars emphasise what the participants have highlighted, the importance of spirituality. This is in line with what Nwoye argues for regarding the Africentric paradigm, which recognises the possibility of the origin of mental distress arising not only from the illness of the body, or that of the mind, or social contexts, as emphasised in the West, but also originating from the spiritual or ancestral background of the individual manifesting the illness. Nwoye (2015a) highlights here that EuroAmerican psychology fails to understand mental illnesses from a spiritual dimension, and he emphasises the value that of dimension in bringing balance to the well-being of individuals is unfathomable.

- Physical Abuse factors

Substance abuse

It is also interesting to note that participants acknowledged substance abuse as a cause of mental distress among the youth. South Africa like other countries is located on major drug trafficking routes, Ettang (2017) states that in SA drug abuse has increased. This shows how easy it is to gain access to substances in the country currently. Illicit drug

use is a growing public health problem, especially among youth. The participants picked up on the consequences of substance abuse and acknowledged behaviours of the youth as contributing to the identified problem. The participants highlighted that the youth are often taken to the traditional healers because they display mental distress. Watt et al. (2015) endorse that substance-abusing youth are at a higher risk for mental health problems, including depression, conduct problems, personality disorders, and suicidal thoughts. What was also puzzling to note is how participants referred to substances as a variable causing mental distress. Yet literature also points out that substance abuse may result from mental distress. National Institute on Drug Abuse (NIDA, 2019) asserts that many individuals who develop substance use disorder are also diagnosed with mental disorders.

- Psycho-social factors

Jealousy and witchcraft

Samir (2019) comments that many Africans view mental distress as a result of external attacks on the individual. The participants explained that jealousy of others' success could cause individuals to seek means of causing harm to those who are succeeding. Sometimes knowledge of this leads to mental distress features for the victims of this jealousy. The jealous person could seek the help of a *sangoma* who uses bad *muti* (herbal medicine). The participants explained that not all traditional healers operate in good faith. There may be some that deal in *muti* that will influence others' mental health. When this takes place, it may have effects on others' cognitive and behavioural functioning. The participants also reported that relational disputes could lead individuals to seek revenge. The participants claim that this revenge can display itself through either victim or perpetrator experiencing mental distress. Those with mental distress are seen to be under some mystical power or spell. This way of making sense of mental distress is not something new but has existed across many cultures over time. Barlow and Durand (2009) state that religious and lay authorities supported these popular superstitions in the last quarter of the 14th Century. Pfeifer (1994) confirms that belief in demons as the cause of mental health problems is a well-known phenomenon in many cultures of the world;

however, there is limited literature on this phenomenon in Protestant subcultures of the West.

Family-related issues

To add to the previous section, disputes with family members whom individuals are close to are also a cause of mental distress. The participants highlighted that when families are no longer of one accord, this can cause a strain on individuals' mental well-being. Boulerice (2015) states how individuals relate to others and how others relate to them has a profound impact on physical and mental health. The participants highlighted the importance of good relations with those around them. Tripathi et al. (2019) confirm that other psychosocial aspects such as social support, family, and culture have an impact on psychiatric disorders thus showing that individual differences are not solely due to neurobiological dysfunctions or biological models. According to Boulerice (2015), all components of the BPS approach need to be integrated for people universally to live functionally and have a satisfying quality of life. Clinicians, healers and health care workers must recognise that relationships are central to providing health care. This is also monitored in Counselling Psychology, as the focus is not only on the individual in therapy, but how the individual relates with others and vice versa.

Psychological factors

Finally, psychological factors were also noted in a limited way as one of the causes of mental distress. Of the five participants, only one mentioned psychological factors as a cause for mental distress. Judging from how the other four participants did not mention psychological factors as a cause for mental distress, it can be assumed that these participants do not put too much emphasis on psychological factors as causes of mental distress. The emphasis is rather placed on spiritual and social factors. Participants did however refer to *amafufunyana* as a psychological cause of mental distress, not a spiritual or social matter. This contrasts with the multidimensional BPS approach. Tripathi et al. (2019) explain that the approach systematically explains the complex interplay between three significant dimensions, biological, psychological, and social, in developing psychiatric disorders. To the participants, it seems that the main dimension worth noting

is social, which focuses on the impacts of the environment and the interconnectedness of people on the individual.

To summarise briefly, the participants seem to understand that mental distress is caused by external stimuli mostly outside of the control of the individual with mental distress. How they define and make sense of the causes of mental distress illustrates their views that external processes impact mental well-being more than internal processes.

Also, looking from Brofennebrenners' (1994) ecological system perspective, when considering how traditional healers make sense of the causes of mental distress, they seem to understand that the systems around the person impact upon and influence the individual's mental well-being. Brofenbrenners' ecological systems theory views development as a complex system of relationships affected by multiple levels of the surrounding environment. Studying a person's development requires looking at the immediate environment as well as focusing on the external systems that impact the person. Looking at the causes mentioned by the participants, the Micro-systems include the close relationships that the person has. The participants referred primarily to the family disputes and how these impact mental distress and include the relationships that individuals have with their ancestors. The Meso-system includes the disputes between members of the wider community and how jealousy and envy can sometimes impact mental health. The Exo-system refers to access to illegal substances the lack of the implementation of stricter laws to limit the sale of substances. Macro-system factors include the role that culture plays and how not following cultural practices might influence the mental state. Finally, the Chrono-system refers to beliefs about the transitioning of a person from mortal to an intermediary between living and spirit and how failing to take up such a task might influence mental well-being. Making sense of the participants' meaning-making demonstrates ways that these ideas might be incorporated into a systemic view. Even though the content may be similar, the terminology may not be the same.

## 5.4. Healing from an African Context

The next section focuses on traditional healing. The World Health Organization defines this method of healing as a "health practices, approaches, knowledge, and beliefs incorporating plant, animal and mineral based medicines, spiritual therapies, manual techniques and exercise, applied singular or in combination, to treat, diagnose and prevent illnesses or maintain well-being (as cited in Mokgobi, 2012). Mlisa (2009) states that *ukuthwasa* is a healing process involving *umbilini* (intuition), dreams, and visions as a core aspect of assessing, diagnosing and treating the sick and those disturbed in various ways. This theme includes spiritual and mystical beings, methods of healing, and attitudes of participants towards western practices.

### 5.4.1 Spiritual and mystical beings

The participants were asked to describe what their job entails. The participants described their job as something very unique and precious. They emphasised that the job was something only a few selected people were chosen to do. They reported that their work included a process of divination. Mlisa (2009) defines this practice as assessing beyond the individual level and checking for hidden things, not just personal issues but family and work-related challenges. This looks for problems outside what is obvious through observation. These healers have the ability and insight to tap into that world of the unseen and reveal what they intuit to be influential. Mlisa (2009) explains that initiates are trained vigorously to do *ukuvumisa* (assessment and diagnosis). This *ukuvumisa* is done by observing the client and diagnosing and predicting the matter. The participants highlighted that this is taught during their training. As much as this is taught during training, they cannot acquire this without communicating with their ancestors. This is part of the gift given by the ancestors to practice as a healer. The participants also noted that their work involves training other novice healers. This illustrates how communal these healers are and how passing on the gift to the next selected healers is essential. This is similar to what psychology offers outside individual counselling. Community psychology is based on the theoretical framework that to fully understand the individual, one must understand the context they come from. Thus, in essence, it goes beyond an individual focus and integrates social, cultural, political and environmental influences (SACAP,

2022). The purpose of community psychology is to influence the individual through empowering the community.

The gift is not meant to be kept to self but to encourage and empower others in the community who might have the same gift. Many refer to this practice of interconnectedness as the "spirit of *Ubuntu"*. According to Baloyi (2008), *Ubuntu* can be described as humanness, be-ing human, knowing one's fellow human beings and taking a keen interest in their well-being. He says that this *Ubuntu* gives Africans their spiritual distinctiveness, characterised by what Magcu (cited in Baloyi, 2008; p.87) refers to as "a fellow feeling for justice towards others". De Bruyn (2017) reports that the second tenet of the Afrocentric paradigm is that all human beings are interconnected and interdependent. Participants demonstrated this spirit of interconnectedness in their work and the communities as evidenced in the extracts provided.

Like medical doctors specializing in certain areas, traditional healers have their speciality. Mokgobi (2014) concurs that traditional healers, like medical doctors, are not homogenous. The work is unique only to that specific traditional healer. The participants also included healing as part of their work. For each participant, their training includes healing specific disorders. This is based on the ancestors' guidance and that of the trainer. There were those whose work did not include divination or training of novice healers but also included healing specific illnesses. Some could heal physical ailments through the applying a special ointment made from herbs, while others claimed that they could heal mental disorders like *amafufunyana*.

### 5.4.2 Methods of healing

Traditional healers play a pivotal role in bringing healing and well-being to the community. Many community members seek their aid with the challenges they encounter and seek healing from the traditional healer. Traditional healing comes in different forms and is guided by the ancestors. Participants mentioned that they use mixtures of plants and herbs to treat people. Although the process of combining these was briefly mentioned, participants reported that they were prohibited from divulging much. The

understanding is that this process is something sacred and should be kept between the healer, trainer and their ancestors. Van der Watt et al. (2020) confirm this by explaining that traditional healers are reluctant to disclose information about the herbs used, claiming that this is a secret only a few can understand. Both Western and African traditional practitioners deem their professions as efficient and something that only a selected few can acquire, even though traditional healing thus far lacks scientific back-up.

Others also reported that they make use of dreams and visions, this is similar to the dream analysis in psychology. It seems that a difference from psychoanalytic forms of dream analysis is that the healer is the only person whose dreams carry profound meaning. The healer has to dream, and from that dream, they are shown what the problem is and how it can be treated. The dreams and visions direct the healer to the presenting problem, diagnosis, and treatment. Finally, bone reading, dice, dominos, and playing cards were mentioned as ways of tapping into the mystical world. According to Ross (2021), the patient or the diviner throws bones on the floor, but ancestral spirits control the pattern. The bones include animal vertebrae, dominoes, dice, coins, shells and stones that carry significant meaning. The diagnosis and treatment are revealed in a series of throws. The healer interprets the allegorical procedure concerning the patients' afflictions, what they intuit that the ancestors require and what actions to take to resolve the problem. These are used as test to discover what is underneath the consciousness of the client, which parallels the work of counselling psychologists when conducting forms of psychological assessments.

### 5.1. Attitudes towards western practices

Contrary to what was anticipated, traditional healers spoke about being keen and interested to work with healthcare practitioners. This is to provide a holistic approach to healing. The participants' attitudes towards Western practices demonstrated the eagerness for such collaboration. Participants foresee themselves working in collaboration with other health care practitioners in providing holistic healing for all. Street (2016) mentions that the Traditional Health Practitioners Act 22 of 2007 aims to create a

council, provide a regulatory framework to ensure the efficiency, safety and quality of traditional healthcare and provide for the management and control over the registration.

Despite the Act, the participants reported that traditional healers sometimes feel they are not given the recognition they deserve. Based on some of the participants' narratives, it also appears to be crucial to have a representative in the HPCSA council. Although the traditional healers are keen on collaborating with Western Practitioners, the participants highlighted that in their experiences, medical practitioners do not reciprocate this. Hopa et al. (cited in Mokgobi, 2014) explain that in a study done during the democratic era in SA, general physicians were against the integration as they questioned the authenticity of the traditional healing practice. This was a concern that some participants highlighted. Not all healers are registered, making the practice of traditional healing challenging to regulate. Some operate outside the scope of practice and act in bad faith, tarnishing all traditional healers' credibility. Hence, the need for assistance from the government in regulating the practice so that this collaboration could be possible.

## 5.5. Summary of training stages

The journey taken in both these professions involves convergent and divergent stages. A traditional healer is chosen by the ancestors and this is not a choice made by the individual. Mlisa (2020) stipulates that a traditional healer is chosen by the ancestors to do the divine work. Whereas a potential masters student psychologist is chosen by the panel of the institutions' staff to be part of the Masters Counselling Psychology group. The traditional healer is chosen mainly because they display signs and symptoms that indicate "ubizo" (which is the divine call). SACAP (2022) reports that there a specific qualities that are expected of a potential Masters student. Mlisa (2020) stipulates that the acceptance of the call includes many rituals and training phases that a novice traditional healer has to undergo through the help of a trained "iqhirha" (a well trained traditional healer). Whereas the student Counselling Psychologist is under the supervision of a trained Counselling Psychologist and undergoes certain additional training within the internship year (RU, 2022). The final stage of a trained traditional healer is acceptance of the calling and graduation. According to Mlisa (2020), this is the last and final stage. It

consist of four activities that one has to achieve or conform to. The training of the student Counselling Psychologist also involves undergoing extensive training both academically and through practical work. For a student Counselling Psychologist there is examination done by the Health Professions Council of South Africa (HPCSA) board to assess whether the student is equipped to assist people with their mental health related issues.

## 5.6. Conclusion

To conclude this chapter, the participants emphasised their role in the community and how much the community values them. They explained that only a few are chosen to carry the task of interceding on behalf of the ancestors. This purpose is to give a rich background to who these participants are and why their voices matter in understanding and making sense of mental distress using African Psychology. Secondly, the participants defined what mental distress means to them and their practice how they can understand and differentiate a person with mental distress. Finally, the study looked at healing from an African context. It focused on the methods participants employ in healing people with features of mental distress. It also focused on the positive attitudes of the participants towards mental health practitioners. The aim here was to gauge where these participants placed themselves on the continuum related to the mental health crisis in SA. The following chapter focus on the conclusions from this discussion. It also focuses on the recommendations and limitations of this study.

# CHAPTER SIX: CONCLUSION

## 6.1. Introduction

This study aimed to conceptualise mental distress from an African psychology paradigm, focusing on the views and perspective of traditional healers. A summary of the findings is presented in this chapter, followed by the researcher's recommendations and the limitations of the study. Finally the chapter ends with the researcher's reflections on the entire process.

## 6.2. Summary

A summary of the findings is presented below. The chapter aims to answer the two research questions identified using the findings from the previous chapter. The two research questions identified were;

- What are traditional healers' lived experiences, and how do they understand the concept of mental distress?
- What methods and processes of healing do traditional healers utilise for dealing with mental distress?

Traditional healers in South African play a vital role in providing healing for those who are mentally distressed in areas where psychological services are inaccessible or unknown. In a country where there is unequal distribution of resources, access to mental health seems to be a growing concern for SA (de la Rey & Ipser, 2004). With a number of factors affecting the mental health of many South Africans, the mental health crisis seems to be on the rise. Many find seeking the help of a traditional healer to be more effective than accessing the limited mental health care facilities. These healers are culturally understood to carry knowledge and special powers in dealing with unknown disturbances that many suffer from.

The aim of this study was to understand and make meaning of how traditional healers conceptualise mental distress when presented with it. Traditional healers refer back to the process of *ukuthwasa* to set the groundwork of who they are and how they fit in

providing their services. These chosen people are bestowed with a gift of healing. The findings indicate that this divine gift brings with it a lot of uncertainty, confusion and trouble. Through the process of *ukuthwasa* the initiate has to accept the call and from the misfortunes that follow them try to heal and aid himself by accepting the wishes of those who are assigned to guide them. The connection that this iniate has with their ancestors will determine the future they will have as a healer.

According to the findings, mental distress is understood by traditional healers as something that makes an individual act and behave differently to how they would normally behave and is also evident to those around them. The views of the traditional healers in defining and conceiving mental distress is represented by the self composed of the harmonious unity between the mind-body-spirit. However, the traditional healers place greater emphasis on the spirit that practices developed in the West fails to acknowledge. Mental distress is said to occur when there is no balance between the three components of the self, as the traditional healers have identified. This correlates with what many scholars of African psychology have argued for.

The methods of healing that traditional healers use to heal mental distress vary, as some are gifted in dealing with the different types of disorders presented such as witchcraft, divine calling, acknowledging rituals and culture-bound syndromes such as *amafufunyana*. From the findings, the participants highlighted that they use dreams, visions, intuition, or throwing of bones to diagnose and assess the clients that are infront of them. According to these participants not everyone has the skill to be able to apply these methods unless the ancestors bestow this power on the healer. Once a diagnosis is established, the ancestors again direct the healer to the treatment method to be applied. This can include performing a ritual, applying ointment, washing with special water, or consuming medication made from different herbs and plants to cleanse the client internally.

The participants perceived their methods of healing as complementary to the Western practices of healing. They acknowledged that their methods alone might not necessarily

solve the mental health crisis that the country is faced with. However, the collaboration between the African Traditional healing practices and the Western healing practices could be more effective in providing holistic healing to the desperate SA.

It was crucial for this study to recruit traditional healers as the participants of the study, because of the prestige and value within their communities. These healers are well-respected and revered by the people around them. Traditional healing practices have existed long before allopathic medicine has existed. Since there has been limited recognition of these and more studies need to be done to acknowledge the important role that these healers play in the community and for the health care system. As many scholars in the study have reiterated, Afrocentricity is about placing emphasis on the supremacy to experiences of Africans. However, participants commented there are healers who actually do more harm than good and it is for this very reason that mandatory registration should be implemented to regulate and protect this practice from bogus healers who claim to have the gift of the divine call but cause harm rather than good.

## 6.3. Recommendations

- The study made use of Interpretative Phenomenological Analysis, which focuses on how the participants make sense of their experiences, the sample size had to be kept small to provide rich and very lengthy data. Further studies on this need to be explored focusing on the different experiences that different traditional healers had, especially differences between the “red” and “white beaded diviners”.
- The study recruited traditional healers who had other careers before deciding to accept the divine call. These healers all have some tertiary education and were trained in other professions before accepting the call. The experiences of traditional healers who have somewhat little to no educational background in other professions might be different, which could be interesting to explore.
- In addition, the participants indicated their willingness to work in collaboration with other health professionals, so this needs to be further explored with evidence generated to inform such practice.

## 6.4. Limitations

The findings of the study are not a general reflection of the experiences of all traditional healers. But the small sample utilized for this study from a confined geographical area in SA, is an indication of the narratives and experiences of some traditional healers. The findings of this study cannot be generalized for all traditional healers. The initial aim of the researcher was to recruit different traditional healers including *sangomas, ixhwele* (herbalist) and faith healers to investigate the different experiences that they all had. Since the researcher could not find other types of traditional healers, only diviners participated.

## 6.5. Reflections of the researcher

As a novice psychologist with a Christian background, I had my reservations about the practices of traditional healing. Before I started this research, my expectations were as follows:

- I was expecting resistance against western methods of healing from the traditional healers;
- I was expecting traditional healers to conceptualize mental distress as something that cannot be cured by Western healing methods, as it was caused by factors outside of the scope of Western methods. This included witchcraft and ancestral or cultural influences. I thought that how they made meaning of the causes of mental distress would be completely different from the Western attribution.
- Thirdly, I expected to find traditional healers treating mental distress with methods unrelated to medication and talk therapy.

Before the process of data collection began, I had judgments around how traditional healers conceptualized mental distress. Some of these judgements were not all positive. However, during collecting data, I gained more insights into how they conceptualized and treated mental distress and developed greater respect for their experiences. The participants that I interviewed had more insight and knowledge of mental distress than I expected, and they did not wholly dismiss Western traditions in curing mental distress. Through this experience there was a lot of learning and questioning about my own identity and culture. I therefore appreciate the role that they played and can see how their

contributions might add to the repertoire of treatments available for people experiencing mental distress, since at present there is relatively limited access to talk therapies and psychological assistance.

# REFERENCE


Abdul Rehman, A., & Alharthi, K. (2016). An introduction to research paradigms. *International Journal of Educational Investigations*, *3*(8), 5159.https://www.researchgate.net/publication/325022648_An_introduction_to research_paradigms

Alase, Abayomi. (2017). The Interpretative Phenomenological Analysis (IPA): A Guide to a Good Qualitative Research Approach. *International Journal of Education and Literacy Studies*. 5. 9-19. 10.7575/aiac.ijels.v.5n.2p.9.

Amankwaa, L. (2016). Creating Protocols for Trustworthiness in Qualitative Research. *Journal of Cultural Diversity*, *23*(3), 121–127.

Asante, M. K. (1991). The Afrocentric Idea in Education. *The Journal of Negro Education, 60*(2), 170-180. 10.2307/2295608

Babbie, E. R. (2007). *The Practise of Social Research*. (11th Edition).Thomson Wadsworth.

Babbie, E. R., & Mouton, J. (2001). *The Practise of Social Research* (South African ed.). Oxford University Press.

Babbie, E., & Mouton, J. (2010). *The Practise of Social Research.* (10th Edition). Oxford University Press.

Baloyi, L. J. (2008). Psychology and Psychotherapy Redefined from the Viewpoint of the African Experience. Unpublished Doctoral thesis. Pretoria, South Africa: University of South Africa

Baloyi, L., & Ramose, M. B. (2016). Psychology and psychotherapy Redefined from the Viewpoint of the African Experience. *Alteration Special Edition*, *18*, 12-35.

Bantjes, J., Kagee, A., & Young, C. (2016). Counselling Psychology in South Africa. *Counselling Psychology Quarterly*, *29*(2), 171-183.

Barlow, D. H., Durand, V. M., & Stewart, S. H. (2009). *Abnormal Psychology: An Integrative Approach*. Toronto: Nelson Education.

Baxter, J.S., & Eyles, J. (1997). Evaluating Qualitative Research in Social Geography: Establishing 'Rigour' in Interview Analysis. *Transactions of the Institute of British Geographers*, 22, 505-525.

Bent, R. J., Packard, R. E., & Goldberg, R. W. (1999). The American Board of Professional Psychology, 1947 to 1997. *Professional Psychology: Research and Practice, 30*(1), 65-73. DOI:10.1037/0735-7028.30.1.65

Berg, A. (2003). Ancestor Reverence and Mental Health in South Africa. *Transcultural Psychiatry, 40*(2), 194-207. 10.1177/1363461503402004

Biggerstaff, D., & Thompson, A. R. (2008). Interpretative Phenomenological Analysis (IPA): A qualitative Methodology of Choice in Healthcare Research. *Qualitative Research in Psychology, 5*(3), 214-224. 10.1080/14780880802314304

Bonache, J., & Festing, M. (2020). Research Paradigms in International Human Resource Management: An Epistemological Systematisation of the Field. *German Journal of Human Resource Management, 34*(2), 99-123. 10.1177/2397002220909780

Booi, B. N. (2004). *Three Perspectives on Ukuthwasa: The View from Traditional Beliefs, Western Psychiatry and Transpersonal Psychology* (Doctoral dissertation, Rhodes University).

Bronfenbrenner, U. (1994). Ecological Models of Human Development. In M. Gauvian & M. Cole (Eds.), Readings on the Development of Children (Vol. 3, 2nd ed., pp. 37 43). Freeman. https:// impactofspecialneeds.weebly.com/uploads/3/4/1/9/3419723/ ecologial_models_of_human_development.pdf

Boulerice, Rebecca. (2015). The Importance of Relationships in Health Psychology: Relationship Effect on Physical and Mental Health.

Butts, H. F. (1979). Frantz Fnon's Contribution to Psychiatry: The Psychology of Racism and Colonialism. *Journal of the National Medical Association, 71*(10), 1015 1018. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2537519/

Cachia, M., & Millward, L. (2011). The telephone medium and semi-structured interviews: A complementary fit. *Qualitative Research in Organizations and Management: An International Journal, 6*(3), 265-277. 10.1108/17465641111188420

Cassidy, E., Reynolds, F., Naylor, S., & De Souza, L. (2011). Using interpretative phenomenological analysis to inform physiotherapy practice: An introduction with reference to the lived experience of cerebellar ataxia. *Physiotherapy Theory and Practice, 27*(4), 263-277. 10.3109/09593985.2010.488278

Charlick, S., Pincombe, J., Mckellar, L., & Gordon, A. (2016). Making sense of participant experiences: Interpretative Phenomenological Analysis in midwifery research. *International Journal of Doctoral Studies, 11*, 205-216. 10.28945/3486

Chawane, M. (2016). The development of Afrocentricity: A historical survey. *Yesterday and Today,* (16), 78-99. 10.17159/2223-0386/2016/n16a5

Chitindingu, E., George, G., & Gow, J. (2014). A review of the integration of traditional, complementary and alternative medicine into the curriculum of South African medical schools. *BMC Medical Education, 14*(1), 40. 10.1186/1472-6920-14-40

Clifford van Ommen. (2007). States of mind : Searching for mental health in natal and Zululand, 1868-1918, Julie Parle. *South African Historical Journal, 59*(1), 282 285. 10.10520/EJC93806

Cokley, K., & Garba, R. (2018). Speaking truth to power: How black/African psychology changed the discipline of psychology. *Journal of Black Psychology, 44*(8), 695 721. 10.1177/0095798418810592

Ebrahim, Zakiyah. *Can Traditional Healers fill South Africa's Mental Healthcare gap?* Health24. https://www.news24.com/health24/news/public-health/can_traditional-healers-fill-south-africas-mental-healthcare-gap-20190903

Cooper, S., & Kramers-Olen, A. L. (2021). Mental health and COVID-19 in South Africa. *South African Journal of Psychology, 51*(2), 304-313. 10.1177/00812463211001543

Cromby, J., Harper, D & Reavey, P. (2013). *Psychology, Mental Health, and Distress*. London: Palgrave Macmillan.

Cumes, D. (2013). South African indigenous healing: How it works. *Explore, 9*(1), 58-65. 10.1016/j.explore.2012.11.007

Dawes, A (1998) Africanisation of psychology: Identities and continents. *Psychology in Society*, 23, 3-16.

De Bruyn, S. (2017). *An Afrocentric enquiry on lived experience of ubuntu among IsiZulu speaking persons from different geographic areas, South Africa* (Doctoral dissertation). https://researchspace.ukzn.ac.za/handle/10413/14369

De le Rey, C, & Ipser, J. (2004). The call for relevance: South african psychology ten years into democracy. *South African Journal of Psychology, 34*(4), 544-552. 10.1177/008124630403400403

Deangelis, T. (2021). Continuing Education Mental Illness and Violence: debunking myths, addressing realities. *Monitor on Psychology*, 31.https://www.apa.org/monitor/2021/04/ce-mentalillness

DiCicco-Bloom, B., & Crabtree, B. F. (2006). The qualitative research interview. *Medical Education, 40*(4), 314-321. 10.1111/j.1365-2929.2006.02418.x

Dlamini, T. S. (2018). *Using Afrocentrism to Explore African Values in Selected Short Stories Prescribed for Grade 10 English First Additional Language Learners in South Africa* (Doctoral dissertation). https://researchspace.ukzn.ac.za/handle/10413/17366

Orb, A., Eisenhauer, L., & Wynaden, D. (2001). Ethics in Qualitative Research. *Journal of Nursing Scholarship*, *33*(1), 93-96.

Ettang, D. O. (2017). 'Desperados, Druggies and Delinquents': Devising a Community based Security Regime to Combat Drug Related Crime. *Africa Development / Afrique et Développement*, *42*(3), 157–176. http://www.jstor.org/stable/90018139

Fade, S. (2004). Using interpretative phenomenological analysis for public health nutrition and dietetic research: A practical guide. *The Proceedings of the Nutrition Society, 63*(4), 647-653. 10.1079/pns2004398

Freeman, M., Nkomo, N., Kafaar, Z., & Kelly, K. (2008). Mental Disorder in People Living with HIV/AIDS in South Africa. *South African Journal of Psychology, 38*(3), 489-500. 10.1177/008124630803800304

Gibson, S., & Sullivan, C. (2018). A changing culture? Qualitative methods teaching in U.K. psychology. *Qualitative Psychology, 5*(2), 197-206. 10.1037/qup0000100

Golafshani, N. (2003). Understanding Reliability and Validity in qualitative research. *The Qualitative Report, 8*(4), 597-607. 10.46743/2160-3715/2003.1870

Goldspink, S., & Engward, H. (2019). Booming clangs and whispering ghosts: Attending to the reflexive echoes in IPA research. *Qualitative Research in Psychology, 16*(2), 291-304. DOI:10.1080/14780887.2018.1543111

Gwala, N. (2021). *Mental Health: Traditional Healers have a huge role to play.* Health-e News.https://health-e.org.za/2021/10/29/mental-health-traditional-healers-have a-huge-role-to-play/

Holder, S., & Wayhs, A. (2014). Schizophrenia. *American Family Physician, 90*(11), 775-82. https://www.researchgate.net/publication/271537933_Schizophrenia

Idemudia. ES (2015). Psychology in Africa or African Psychology? Discourse on the paradigm shift in psychotherapy and psychological practice in Africa. *World Journal of Psychotherapy*, *1*(8): 2-7.

Ivanescu, C., & Berentzen, S. (2020). Becoming a Shaman: Narratives of Apprenticeship and Initiation in Contemporary Shamanism. *Religions*, *11*(7), 362.

Johnson, S., & Rasulova, S. (2017). Qualitative research and the evaluation of development impact: Incorporating authenticity into the assessment of rigour.*Journal of Development Effectiveness,* *9*(2), 1-14. 10.1080/19439342.2017.1306577

Juma, J. O. (2011). *African worldviews: their impact on psychopathology and psychological counselling* (Unpublished master's thesis). University of South Africa

Kale R. (1995). Traditional Healers in South Africa: a parallel health care system. *BMJ (Clinical research ed.)*, *310*(6988), 1182–1185. https://doi.org/10.1136/bmj.310.6988.1182

Kubeka, N. P. (2016). *The Psychological Perspective on Zulu Ancestral Calling: A Phenomenological Study* (Doctoral dissertation, University of Pretoria) https://repository.up.ac.za/handle/2263/57191

Kvale, S., & Brinkmann, S. (2009). *Interviews: Learning the craft of qualitative research interviewing*. Los Angeles, CA: Sage Publications.

Laher, S. (2014). An overview of illness conceptualizations in African, Hindu, and Islamic Traditions: Towards cultural competence. *South African Journal of Psychology, 44*(2), 191-204. 10.1177/0081246314528149

Long, W. (2016). On the Africanization of Psychology. *South African Journal of Psychology*. *43*(3), 278-288.

Long, W. (2017). Essence or experience? A new direction for African psychology. *Theory & Psychology*, *27*(3), 293312.https://scholar.google.com/citations?view_op=view_citation&hl=en&user=z2rQkAAAAJ&citation_for_view=_hz2rQkAAAAJ:M3ejUd6NC8C

Long, W. (2013). RETHINKING RELEVANCE: South African psychology in context. *History of Psychology, 16*(1), 19-35. 10.1037/a0029675

Long, W., & Foster, D. (2013). The changing face of "relevance" in South African psychology. *Psychology in Society,* (45), 3. http://www.scielo.org.za/scielo.php?script=sci_abstract&pid=S101560462013000200002&lng=en&nrm=iso&tlng=en

Lund, C., Kleintjes, S., Campbell-Hall, V., Mjadu S., Petersen I., Bhana, A., Kakuma, R., Mlanjeni, B., Bird, B., Drew, N., Faydi, E., Funk, M., Green, A., Omar, M., Flisher, A.J. 2008. Mental health policy development and implementation in South Africa: a situate analysis. Retrieved from: http://www.who.int/mental_health/policy/development/SA20Country%20Report%2 0-%20Final%20Draft%20Jan%202008.pdf

Lund, C., Myer, L., Stein, D. J., Williams, D. R., & Flisher, A. J. (2012). Mental illness and lost income among adult South Africans. *Social Psychiatry and Psychiatric Epidemiology, 48*(5), 845-851. 10.1007/s00127-012-0587-5

Macleod, C. (2004). South African Psychology and 'Relevance': Continuing Challenges. *South African Journal of Psychology*, *34*(4), 613-629.

Makhubela, M. (2016)."From psychology in Africa to African psychology": Going nowhere slowly. *Psychology in Society*, (*52*), 1-18.

*Makupula, M. (2019). Listening to silenced voices: The lived experiences of Xhosa mothers during the initiation period of their sons* (Doctoral dissertation, University of Fort Hare.

Marder Stephen, R., & Cannon Tyrone, D. (2019). Schizophrenia. *The New England Journal of Medicine, 381*(18), 1753-1761. 10.1056/NEJMra1808803

Mazama, A. (2001). The Afrocentric paradigm: Contours and definitions. *Journal of Black Studies, 31*(4), 387-405. 10.1177/002193470103100401

McFarlane, C. (2015). South Africa: The rise of traditional medicine. *Insight on Africa, 7*(1), 60-70. 10.1177/0975087814554070

Mkhize Velaphi. (n.d.). *African ancestors(ZA).* https://www.southafrica.net/za/en/travel/article/african-ancestors. /za/en/travel/article/african-ancestors

Mkhize, N. J. (2004). Psychology: An African perspective. In D. Hook (Ed.), *Critical psychology* (pp. 24–52). Lansdowne: University of Cape Town Press.

Mkhize, Nhlanhla & Ndimande-Hlongwa, Nobuhle. (2014). African Languages, Indigenous Knowledge Systems (IKS), and the Transformation of the Humanities and Social Sciences in Higher Education. Alternation. Volume 21,2. 10-37.

Mkhize, N. (2020). African/afrikan-centered psychology. *South African Journal of Psychology, 51*(3), 422-429. 10.1177/0081246320972002

Mlisa, L. N. (2009). *Ukuthwasa initiation of amagqirha: Identity construction and the training of Xhosa women as traditional healers. (Doctoral dissertation, University of Free State.* http://etd.uovs.ac.za//theses/available/etd03302010115242/restricted/

Mlisa, L. (2020). I am an igqirha (healer): phenomenological and experiential spiritual journey towards healing identity construction. Numen. 22. 220-239. 10.34019/2236 6296.2019.v22.29618.

Mndende, N. (2002). *Signifying practices: Amaxhosa ritual speech.* (Doctoral dissertation, University of Cape Town). Retrieved from http://hdl.handle.net/11427/7720

Mokgobi, M. G. (2012). *Views on traditional healing: Implications for integration of traditional healing and Western medicine in South Africa* (Doctoral dissertation).

Mokgobi, M. G. (2014). Understanding traditional African healing. *African Journal for Physical Health Education, Recreation, and Dance, 20*(Suppl2), 24 34. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4651463/

Moshabela, M., Zuma, T., & Gaede, B. (2016). Bridging the gap between biomedical and traditional health practitioners in South Africa. *South African Health Review, 2016*, 83-92.

Mothibe, M. E. , & Sibanda, M. (2019). African Traditional Medicine: South African Perspective. In (Ed.), Traditional and Complementary Medicine. IntechOpen. https://doi.org/10.5772/intechopen.83790

Mpono, L. J. (2007). *TRADITIONAL HEALING AMONG THE NGUNI PEOPLE* (Doctoral dissertation, University of KwaZulu Natal)

Mzimkulu, K. G., & Simbayi, L. C. (2006). Perspectives and practices of Xhosa speaking African traditional healers when managing psychosis. *International Journal of Disability, Development, and Education*, 53(4), 417-431.

National Institute on Drug. (2019). *Mental health*. https://nida.nih.gov/drug-topics/mental health

Newcomb, M., Burton, J., Edwards, N., & Hazelwood, Z. (2015a). How Jung's concept of the wounded healer can guide learning and teaching in social work and human services. *Advances in Social Work and Welfare Education, 17*(No 2), 55 69.https://www.researchgate.net/publication/285591160_How_Jung's_concept of the wounded healer can guide learning and teaching in social work and human services

Nguse, S., & Wassenaar, D. (2021). Mental health and COVID-19 in South Africa.*South African Journal of Psychology, 51*(2), 304-313. 10.1177/00812463211001543

Njenga F. (2007). The concept of mental disorder: an African perspective. *World psychiatry: official journal of the World Psychiatric Association (WPA)*, *6*(3), 166 167.

Nicholas, L. J. (2014). A history of South African (SA) psychology. *Universitas Psychologica, 13*(5), 1983–1991. https://doi.org/10.11144/Javeriana.upsy13 5.hsap

Niehaus, D. J., Oosthuizen, P., Lochner, C., Emsley, R. A., Jordaan, E., Mbanga, N. I., Keyter, N., Laurent, C., Deleuze, J. F., & Stein, D. J. (2004). A culture-bound syndrome 'amafufunyana' and a culture-specific event 'ukuthwasa': differentiated by a family history of schizophrenia and other psychiatric disorders. *Psychopathology*, *37*(2), 59–63. https://doi.org/10.1159/000077579

Noyoo, N. (2007). Indigenous knowledge systems and their relevance for sustainable development: A case of Southern Africa. *Tribes and Tribals*, *1*, 167-172.

Nsamenang, A. B. (2006). Human ontogenesis: An indigenous African view on

development and intelligence. *International Journal of Psychology, 41*(4), 293-297. 10.1080/00207590544000077

Nwoye, A. (2006). Remapping the fabric of the African self: A synoptic theory. *Dialectical Anthropology, 30*(1/2), 119-146. https://www.jstor.org/stable/29790757

Nwoye, A. (2015a). African psychology and the Africentric paradigm to clinical diagnosis\ and treatment. *South African Journal of Psychology*, *45*(3), 305-317. https://doi.org/10.1177/0081246315570960

Nwoye, A. (2015b). What is African psychology the psychology of? *Theory & Psychology, 25*(1), 96–116. https://doi.org/10.1177/0959354314565116

Nwoye, A. (2017). A postcolonial theory of African psychology: A reply to Kopano Ratele. *Theory & Psychology, 27*(3), 328-336. 10.1177/0959354317700000

Nwoye, A. (2020). From psychological humanities to African psychology: A review of sources and traditions. *Oxford Research Encyclopedia of Psychology.* https://oxfordre.com/psychology/view/10.1093/acrefore/9780190236557.001.0001/acrefore-9780190236557-e-659

Opdenakker, R. (2006). Advantages and disadvantages of four interview techniques in qualitative research [electronic journal]. *Forum Qualitative Sozialforschung / Forum: Qualitative Social Research, 7(4)* https://www.researchgate.net/publication/48666088_Advantages_and_Disadvantages_of_Four_Interview_Techniques_in_Qualitative_Research_Electronic_Journal

Parle, J. (2004). *States of mind: mental illness and the quest for mental health in Natal and Zululand, 1868-1918* (Doctoral dissertation).

Pathak, V., Jena, B., & Kalra, S. (2013). Qualitative research. *Perspectives in Clinical Research*, *4*(3), 192. DOI:10.4103/2229-3485.115389

Pfeifer, S. (1994). Belief in demons and exorcism in psychiatric patients in Switzerland. *British Journal of Medical Psychology, 67*(3), 247-258. 10.1111/j.2044-8341.1994.tb01794.x

Pham, L. (2018). *A review of key paradigms: Positivism, interpretivism and critical inquiry*. Unpublished. 10.13140/rg.2.2.13995.54569

Pietkiewicz, I., & Smith, J.A. (2012). A Practical Guide to Using Interpretative Phenomenological Analysis in Qualitative Research Psychology, *Psychological Journal*, *20*, 1, 7-14.

Pietkiewicz, I., & Smith, J. A. (2014). A practical guide to using Interpretative Phenomenological Analysis in qualitative research psychology. *Psychological Journal*, *20*(1), 7-14.

Podolecka, A. (2016). Sangomas, Shamans and New Age: the Hybridity of some Modern Healing and Esoteric Practices and Beliefs in South Africa. *Rocznik Orientalistyczny*,(1).
From:https://www.researchgate.net/publication/351100145_Sangomas_Shamanand_New_Age_the_Hybridity_of_some_Modern_Healing_and_Esoteric_Practice_and_Beliefs_in_South_Africa

Ponelis, S. R. (2015). Using interpretive qualitative case studies for exploratory research in doctoral studies: A case of information systems research in small and medium enterprises. *International Journal of Doctoral Studies, 10*, 535 550. https://www.informingscience.org/Publications/2339?Source=%2FJournal%2FIJDS%2FArticles%3FVolume%3D0-0

Ratele, K. (2017a). Four (African) psychologies. *Theory & Psychology*, *27*(3), 313–327. https://doi.org/10.1177/0959354316684215

Ratele, K. (2017b). Frequently asked questions about African psychology. *South African Journal of Psychology*, *47*(3), 273–279. https://doi.org/10.1177/0081246317703249

Ratele, K. (2018). Toward cultural (African) psychology. *The challenges of cultural psychology* (1st ed., pp. 250-268). Routledge. 10.4324/9781315559667-17

Resnik, D. (2020). *What is ethics in research & why is it important?* National Institute of Environmental Health Sciences. https://www.niehs.nih.gov/research/resources/bioethics/whatis/index.cfm

Rhodes University (June,2022).Professional Masters Programme in Counselling Psychology.
https://www.ru.ac.za/psychology/courses/mastersincounsellingpsychology/#d.en. 58626

Ross, W. (2021). Throwing the bones: Finding your future. Spirituality & Health. https://www.spiritualityhealth.com/articles/2021/02/05/throwing-the-bones

Rudd, B. (2014). *Introduction to psychopathology*. London: Sage

Smith, J.A. & Osborn, M. (2008) Interpretative phenomenological analysis. In J.A. Smith (Ed.) *Qualitative Psychology: A practical guide to research methods* (pp. 53-80). London: Sage

South African College of Applied Psychology. (2019). *6 important qualities that a psychology student needs to have*

. https://www.sacap.edu.za/blog/management-leadership/qualities-of-a psychology-student//

South African College of Applied Psychology. (2019). *The shocking state of mental health in South Africa in 2019: Management and Leadership.* https://www.sacap.edu.za/blog/management-leadership/mental-health-south-africa/

Samir Abi. (2019). *In west africa, traditional or religious practices are often the preferred method of treating mental disorders.* D+C: Development and cooperation. https://www.dandc.eu/en/article/west-africa-traditional-or-religious practices-are-often-preferred-method-treating-mental

Seely, A. J. E. (2010). Introduction—evolving research paradigms. *Journal of Critical Care, 25*(3), e1. 10.1016/j.jcrc.2010.05.006

Shai, K. B. (2020). Mokoko sebola on 'scientific knowledge in Africa': An Afrocentric critique. *African Renaissance, 17*,143. https://link.gale.com/apps/doc/A666231691/AONE?u=anon~251ca7bd&si =googleScholar&xid=5df62bbb

Sher Daniel, L. W. (2012). Historicising the relevance debate: South African and American psychology in context. *South African Journal of Psychology, 42*(4), 564 575. 10.10520/EJC128244

Smith, J. (2003). *Qualitative psychology: A practical guide to research methods*. Sage Publications, Inc.

Smith, J. A., Flowers, P., & Larkin, M. (2009). Interpretative Phenomenological Analysis: Theory, Method and Research. Thousand Oaks, CA: Sage Publications

Schauer, B., Kishori, K., Lemieux,L.,& Willey, K. (2016). How Immersion in Nature Impacts the Human Spirit: A Phenomenological Study. Retrieved from Sophia, the St. Catherine University repository website: https://sophia.stkate.edu/ma_hhs/8

Sorsdahl, K., Stein, D. J., Grimsrud, A., Seedat, S., Flisher, A. J., Williams, D. R., & Myer, L. (2009). Traditional healers in the treatment of common mental disorders in South Africa. *The Journal of Nervous and Mental Disease, 197*(6), 434-441. 10.1097/NMD.0b013e3181a61dbc

Starkowitz, M. (2013). *African traditional healers' understanding of depression as a mental illness: implications for social work practice* (Doctoral dissertation, University of Pretoria).

Street, R. A. (2016). Unpacking the new proposed regulations for South African traditional health practitioners. *South African Medical Journal, 106*(4), 325-326. 10.7196/samj.2016.v106i4.10623

Swartz, L. (1999). Culture and mental health - A Southern African view. *Health SA = SA Gesondheid, 4*(1), 27. 10.4102/hsag.v4i1.7

Terre Blanche, M. J., Durrheim, K., & Painter, D. (2006). *Research in practice: Applied methods for the social sciences* (Second Revised Edition.). UCT Press.

Terre Blanche, M. J., Durrheim, K., & Painter, D. (2014). *Research in practice: Applied methods for the social sciences* (Second Edition.). Juta and Company Ltd.

Tessier, S. (2012). From field notes, to transcripts, to tape recordings: Evolution or combination? *International Journal of Qualitative Methods, 11*(4), 446-460. 10.1177/160940691201100410

Thule, G. (2018). *When you feel called to be A healer.* Sacred Liberation Healing Arts. https://www.sacredliberation.com/blog/when-you-feel-called-to-be-a-healer

Tripathi, A., Das, A., & Kar, S. K. (2019). Biopsychosocial model in contemporary psychiatry: Current validity and future prospects. *Indian Journal of Psychological Medicine, 41*(6), 582-585. 10.4103/IJPSYM.IJPSYM_314_19

Tufford, L., & Newman, P. (2012). Bracketing in qualitative research. *Qualitative Social Work, 11*(1), 80-96. 10.1177/1473325010368316

UKPABI, S. C. (1970). Western education and African culture. *Présence Africaine,* (75), 163-172. https://www.jstor.org/stable/24348839

United Nations Office for Drug Control and Crime Prevention, (UNODCCP). (1999). *SOUTH AFRICA COUNTRY PROFILE ON DRUGS AND CRIME part I: Drugs*

University of Oxford. (2021). *Informed consent.* University of Oxford. https://researchsupport.admin.ox.ac.uk/governance/ethics/resources/consent

van Ommen, C. (2007). Book review: States of mind: Searching for mental health in Natal and Zululand. *South African Historical Journal*. 59(1), 282-285 Retrieved from http://www.tandfonline.com/doi/abs/10.1080/02582470709464781

van der Watt, A., Das-Brailsford, P., Mbanga, I., & Seedat, S. (2020). South African isiXhosa traditional healer self-identification, training, practices, and their perceptions of collaboration with medical providers : An exploratory study. *South African Journal of Psychology, 50*(1), 115-127.

Wamba, A., & Groleau, D. (2012). Constructing collaborative processes between traditional, religious, and biomedical health practitioners in cameroon. *Nordic Journal of African Studies, 21*(2), 4974. .http://gateway.proquest.com/openurl?url_ver=Z39.88 2004&res_dat=xri:bsc:&rft_dat=xri:bsc:rec:iibp:00442512

*Warning Signs and Risk Factors for Emotional Distress*. Substance Abuse and Mental Health Service Administration. (2021). Retrieved 21 March 2022, from https://www.samhsa.gov/find-help/disaster-distress-helpline/warning-signs-risk factors.

10.1177/0081246319856984

Watt, M H, Myers, B, Towe, S L, & Meade, C S. (2015). The mental health experiences and needs of methamphetamine users in Cape Town: A mixed-methods study. *SAMJ: South African Medical Journal*, *105*(8), 685 688.https://dx.doi.org/10.7196/SAMJNEW.7910

Welman, J. C., Kruger, F., Mitchell, B., & Huysamen, G. K. (2005). *Research methodology.* (3rd ed.). Oxford University Press.

Young, C., & Saville Young, L. (2019). Comparing clinical and counselling psychologists' practitioner demographics, key activities, theoretical orientations, values, and

career satisfaction: A contribution to the scopes of practice debate. *South African Journal of Psychology, 49*(4), 505-517. 10.1177/0081246318823188

Zhandire, T., Gqaleni, N., Ngcobo, M., & Gomo, E. Attitudes and perceptions of traditional health practitioners towards documentation of patient health information in their practice in eThekwini Municipality, KwaZulu-Natal, Natal Province, South Africa.*Health information management: journal of the Health Information Management Association of Australia*, 1833358320984004.

Zikalala, M. (2017). African vs western psychology. *Academia Letters,*https://www.academia.edu/32056896/African_Vs_Western_Psychology

Zwane, C. L. (2020). The morphological analysis of Zulu clan names. *English Linguistics Research,9*(3), 36. 10.5430/elr.v9n3p36

# Appendix A: RPERC approval letter

RHODES UNIVERSITY
*Where leaders learn*

Human Ethics subcommittee
Rhodes University Ethical Standards Committee
PO Box 94, Grahamstown, 6140, South Africa
t: +27 (0) 46 603 8055
f: +27 (0) 46 603 8822
e: ethics-committee@ru.ac.za

www.ru.ac.za/research/research/ethics
NHREC Registration no. REC-241114-045

13 July 2020

Sandisiwe Nabo- Bazana

Email: g20n8663@campus.ru.ac.za

Review Reference: 2020-1305-3576

Dear Prof Akhurst

**Title:** Conceptualizing psychopathology from an African Psychology paradigm: using Interpretative Phenomenological Analysis

Principal Investigator: Prof Jacqueline Akhurst

Collaborators: Mrs. Sandisiwe Nabo-Bazana,

This letter confirms that the above research proposal has been reviewed and **APPROVED** by the Rhodes University Ethical Standards Committee (RUESC) – Human Ethics (HE) sub-committee.

Approval has been granted for 1 year. An annual progress report will be required in order to renew approval for an additional period. You will receive an email notifying when the annual report is due.

Please ensure that the ethical standards committee is notified should any substantive change(s) be made, for whatever reason, during the research process. This includes changes in investigators. Please also ensure that a brief report is submitted to the ethics committee on the completion of the research. The purpose of this report is to indicate whether the research was conducted successfully, if any aspects could not be completed, or if any problems arose that the ethical standards committee should be aware of. If a thesis or dissertation arising from this research is submitted to the library's electronic theses and dissertations (ETD) repository, please notify the committee of the date of submission and/or any reference or cataloging number allocated.

Sincerely,

**Prof Arthur Webb**

**Chair: Human Ethics Sub-Committee, RUESC- HE**

## Appendix B: Information Sheet

INFORMATION LETTER TO POTENTIAL PARTICIPANT
INVITATION TO PARTICIPATE IN A RESEARCH
STUDY/INFORMATION SHEET ABOUT THE RESEARCH

My name is Sandisiwe Nabo-Bazana. I am a master's student at Rhodes University (RU). The research I wish to conduct for my master's thesis investigates how traditional healers conceptualise and understand mental distress. Your subjective experiences and understanding of mental distress will assist us in gaining a better understanding of this phenomenon which will aid in an intervention. This project will be conducted under the supervision of Professor Jacqueline Akhurst (Department of Psychology, RU).

I am hereby contacting you to see whether you will be willing to be involved in this research study. If you consent to be part of this study, you will be asked to participate in an interview lasting approximately 45- 60 minutes. This session will be based on your clients' lived experiences dealing with mental distress.

You are free to withdraw from the session and withdraw your data should you not wish to part-take anymore. I will be translating the sessions into the South African language you are comfortable in.

I have provided you with a copy of the ethics approval letter from the Rhodes University RU. Ethics Standards Committee (RUESC). Everything you say will remain confidential and anonymous. The confidentiality of your clients and work will always be respected. If you require any further information, please do not hesitate to contact me through the following:

Cellular: 083 490 3925

Email: sifanelwen@gmail.com

I look forward to hearing from you.

Yours sincerely

Sandisiwe Nabo- Bazana

(Under supervision from Professor J Akhurst)

# ISIMEMO SOKUTHATHA INXAXHEBA KWISIFUNDO SOPHANDO / ISICWANGCISO SOLWAZI NGOKUFUNDA

Igama lam ndingu Sandisiwe Nabo-Bazana, ndinguMfundi kwiYunivesithi yase Rhodes (RU). Uphando endinqwenela ukuluqhubela phambili ngala mxholo wesidanga se masters zam luphonononga indlela amaxhwele aqaphela kwaye aqonde ngayo uxinzelelo lwengqondo. Amava akho aphelayo kunye nokuqonda koxinzelelo lwengqondo kuya kusinceda ukuba siyiqonde ngcono ngale meko eza kuthi incede kungenelelo. Le projekthi iza kuqhutywa phantsi kweliso likaNjingalwazi uJacqueline Akhurst (iSebe lezeengqondo, eRU).

Ndiza kunxibelelana nawe ukuze ubone ukuba uyakuvuma ukubandakanyeka kolu phando. Ukuba uyavuma ukuba yinxalenye yolu phononongo, uya kucelwa ukuba uthathe inxaxheba kudliwanondlebe oluhlala malunga nemizuzu engama- imizuzu engamashumi amane anesihlanu uyotsho kwamashumi amathandathu emizuzu. Le seshoni iya kusekelwa kumava akho okuphila ajongene nokubandezeleka kwengqondo kubaxhasi bakho.

Ukhululekile ukurhoxa kwiseshoni, kwaye ukurhoxisa ngolwazi lwakho ukuba awunakunqwenela ukuthatha inxaxheba kwakhona. Ndiza kuguqulela iiseshoni kulwimi lwaseMzantsi Afrika okhululekileyo kulo.

Ndikunike ikopi yeleta yokuvunywa kwemigaqo yokuziphatha evela kwiKomiti yemiGangatho ye-RU yokuziphatha. Yonke into oyithethayo iya kuhlala iyimfihlo kwaye ingaziwa. Ubufihlo babathengi bakho kunye nomsebenzi uyakuhlala uhlonitshwa. Ukuba ufuna nayiphi na ingcaciso engaphezulu, nceda ungathandabuzi ukuqhagamshelana nam ngezi zinto zilandelayo:
Iiselfowuni: 083 490 3925 I-imeyile: sifanelwen@gmail.com
Ndakuvuyiswa kukukuva kuwe.
Ozithobileyo
Sandisiwe Nabo- Bazana
(Phantsi kweliso likaNjingalwazi J Akhurst)

# Appendix C:Informed Consent

RHODES UNIVERSITY

Grahamstown • 6140 • South Africa

RHODES UNIVERSITY - DEPARTMENT OF PSYCHOLOGY

AGREEMENT BETWEEN STUDENT RESEARCHER AND

RESEARCH PARTICIPANT

I _____ (participant's name) agree to participate in the research project of Sandisiwe Nabo- Bazana on Conceptualizing psychopathology from an African Psychology paradigm: using IPA.

I understand the following.

1) The researcher is a student researching as part of the requirements for a master's degree at Rhodes University. The researcher may be contacted on 083 490 3925 or sifanelwen@gmail.com. The research project has been approved by the relevant ethics committee(s) and is under the supervision of Professor Jacqueline Akhurst in the Psychology Department at Rhodes University, who may be contacted on 046 603 8500 or j.akhurst@ru.ac.za

☐

2) The researcher is interested in exploring how traditional healers conceptualize and make sense of mental distress. The researcher is interested in how the traditional healers convey their lived stories in dealing with distressed clients.

☐

3) My participation will involve individual semi-structured interviews that will be approximately 45-60 minutes. This will be done at a time where it will not interfere with my work commitments.

4) I may be asked to answer questions of a personal nature, but I can choose not to answer any questions about aspects of my life which I am not willing to disclose.

☐

5) I am invited to voice to the researcher any concerns I have about my participation in the study, or consequences I may experience as a result of my participation, and to have these addressed to my satisfaction.

☐

6) I am free to withdraw from the study at any time – however, I commit myself to full participation unless some unusual circumstances occur, or I have concerns about my participation which I did not originally anticipate.

☐

7) The report on the project may contain information about my personal experiences, attitudes, and behaviours, but that the report will be designed in such a way that it will not be possible to be identified by the general reader.

☐

Signed on (Date):

Participant: _____ Researcher: _____

# Appendix D: Permission to record

**Rhodes University — Department of Psychology**

## USE OF TAPE RECORDINGS FOR RESEARCH PURPOSES PERMISSION AND RELEASE FORM

| | | | |
|---|---|---|---|
| Name of participant | | | |
| Participant's contacts details | Email address:<br>Phone number: | | |
| Name of researcher | | | |
| Level of research | Honours | Masters | PhD |
| Brief title of project | | | |
| Name of supervisor | | | |

**DECLARATION**

*(Please initial/tick blocks next to the relevant statements)*

| | | | |
|---|---|---|---|
| 1. | The nature of the research and the nature of my participation have been explained to me. | verbally | |
| | | in writing | |
| 2. | I agree to be interviewed and to allow recordings to be made of the interview. | audiotape | |
| | | videotape | |
| 3. | I agree to _____ and to allow recordings to be made. | audiotape | |
| | | videotape | |
| 4. | The tape recordings may be transcribed | without conditions | |
| | | only by the researcher | |
| | | by one or more nominated third parties | |
| 5. | I have been informed by the researcher that the tape recordings will be erased once the study is complete and the report has been written. | | |
| | OR | | |
| | I give permission for the tape recordings to be retained after the study and for them to utilised for the following purposes and under the following conditions | | |

Signature of participant: _____ Date: _____

Witnessed by researcher: _____ Date: _____

# Appendix E: Interview Schedule

Conceptualising psychopathology from an African Psychology paradigm: using Interpretative Phenomenological Analysis.

Interview schedule for semi-structured individual interviews

Section A:

Place_____

Date_____

Age_____ Gender_____

Occupation_____

Level of education_____

1. Please tell me what your work entails?
2. Could you tell me how you got into this form of work? How did you become a traditional healer?
3. Please can you take me through the process of your work?

Section B:

1. What are the lived experiences of traditional healers when dealing with mental distress?

a) How do you tell if someone is mentally distressed?

b) How is mental distress different from “ukuthwasa”?

2. How is the concept of mental distress understood by traditional healers?

a) How do you make sense of mental distress?

b) Based on your experience, what have you noticed as the cause of distress in clients?

3. What methods and processes of healing do traditional healers utilise for mental distress?

a) How do you go about treating the mentally distressed?

b) Do you ever refer a client onwards for another form of medical or social assistance? If yes, when?

c) Do you have any experience of a psychologist's work? What are your thoughts about integrating this form of assistance in treating mentally distressed clients?