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TITLE: EXPLORING THE INDEGENOUS AFRICAN WORLDVIEW OF MENTAL ILLNESS, PSYCHOLOGICAL WELL-BEING, AND TRADITIONAL HEALING SYSTEMS AMONGST THE RURAL XHOSA-SPEAKING OF THE EASTERN CAPE.

DECLARATION

Submitted in fulfilment of the requirements for the degree in Master of Social Sciences by Dissertation in the discipline of Psychology, University of KwaZulu-Natal Howard College campus, the faculty of Applied Human Sciences.

I Sophumelela Tontsi declare that this research is my own work which I have never previously submitted to any other institution for any purpose. The work of other researchers and authors have been re-rephrased including borrowed ideas and data all of which is referenced and duly acknowledged, including direct quotes from other authors and or researchers in this case, the researcher used direct quotation marks and the page numbers have been provided. This dissertation does not include ideas and information from the internet, in the case of defining concepts the internet was used and these are clearly cited and referenced in the reference list.

Miss S. Tontsi (author) .....……...

MRS N. A. Mtwentula-Ndlovu (supervisor) ……

Date ….....

ABSTRACT

Psychological maladjustment is conceptualised diversely over social and religious gatherings, additionally the views of dysfunctional behaviour that are held in different contexts and cultures; play a significant role in the treatment sought and the reaction to the treatment. Black people in South Africa such as Xhosa, Sotho, Zulu, Tswana and many others, draw their insight from various perspectives, and these perspectives inform their conceptualisation regarding psychological instability.

The findings in this study revealed that psychological illness in the Xhosa community is conceptualised differently to the Western conceptualisations. The view of psychological maladjustment held by the Xhosa people impacts the kind of treatment looked for, with the decision of treatment frequently being indigenous healing. Besides the social convictions which make indigenous healing the principal alternative for treatment, financial status, and the expense of psychological care were likewise highlighted by most participants as one of the factors that hinder help seeking.

The findings of the current research also suggest that there is a strong link between the aetiological beliefs of the participants and their conception and understanding of mental illness. Furthermore, the majority of participants have a more African orientation to the understanding of mental illness, were they mostly believe the cause of psychological abnormalities to be more related to African traditions. Nonetheless, the results also show that the participants do endorse a Western orientation to the aetiology of mental illnesses. Some participants believed that psychological challenges can be caused by social factors such as drug and alcohol abuse; dysfunctional families; poverty and unemployment. On the other hand, participants suggested that traditional healers play a significant role in the treatment of mental illnesses. Furthermore, the results suggest that traditional healers offer an alternative form of intervention especially in rural areas were most people do not have easy access to mental healthcare institutions and the necessary resources for psychological wellbeing.

KEY CONCEPTS: **African Psychology; African people; African ways; African-worldview; Eurocentric**; **Holistic-healing; Indigenous knowledge**; **Mental illness; Traditional healer; Xhosa.**

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DEFINITION OF KEY TERMS

1. **AFRICAN PSYCHOLOGY:** A conceptual framework that attempts cognisant and purposeful endeavours to focus mental inquiries and application in African realities; sociocultural context; and epistemologies. A comprehensive system that reviews the strategies that grant for the clarification and arrival of the spiritual domain by utilising African indigenous conviction, in light of the estimations of unity in the universe as a characteristic request of existing (Bomoyi, 2011).
2. **AFRICAN PEOPLE: "**Blacks who are sharing the same cultural backgrounds, norms, values and beliefs as Africans" (Mkhize & Uys, 2004, p.63). Furthermore, African people refer to Black people residing in South Africa, including Zulu; Xhosa; Tsonga; Venda and Sotho people and excluding Whites; Coloureds and Indians in this regard (Thabede, 2008, p.233).
3. **AFRICAN WAYS:** "traditional views that underpin the causes of mental illness. These views of mental illness are described as a disturbance in the whole being, also taking into account the powers of protection of the ancestors, witchcraft and spirit forces" (Mkhize & Uys, 2004; p.63).
4. **AFRICAN WORLDVIEW:** A theoretical framework which controls the philosophical conventions and standards on which individuals' convictions are based. The conceptual framework, through which individuals identify their experiences, is the primary determinant of how they conceptualise; reason; and experience their reality (Melato, 2000; Thabede, 2008).
5. **EUROCENTRIC:** Highlights the Western methods which has generally been used and applied globally as the institutionalised and all-inclusive method for getting things done. The framework is considered to be universal; unbiased; and value-free and is regularly not open to the thought of sociocultural difference (Bomoyi, 2011).
6. **HOLISTIC HEALING:** a framework that can keep up balance among all parts of a client's life including the psyche, physical; and spiritual by inspecting the cultural domain; the background of the person; and current condition (Bomoyi, 2011).
7. **INDIGENOUS KNOWLEDGE:** Indigenous knowledge is described by its embeddedness in the way of life and history of a people, including their human advancement and is the sociocultural; and economic identity of such people (Bomoyi, 2011; ODora-Hoppers, 2001).
8. **MENTAL ILLNESS:** is defined as "a condition which causes serious disorder in a person's behaviour or thinking" *(English Oxford living dictionaries).* In this current study deferrent

concepts will be used interchangeably to refer to mental illness; i.e. psychological illnesses, psychological abnormalities, psychological malfunction, psychological maladjustment; psychological instability, emotional or psychological distress, psychopathology/ pathology etc.

9. **TRADITIONAL HEALER:** is perceived as an individual that is recognised by the community as skilled to give health services by utilising traditional herbs and different strategies dependent on the convictions; knowledge of the culture; and religion predominant in the society with respect to psychological; physical; and social welfare; and aetiology of illness (Bomoyi, 2011).
10. **XHOSA:** An individual from South Africa, customarily living in the area of Eastern Cape. AmaXhosa, structure the second biggest ethnic community in South Africa after the Zulu people (*English Oxford living dictionaries*).

CHAPTER ONE: BACKGROUND OF THE RESEARCH STUDY

1.1 INTRODUCTION

The process for encountering mental health issues is fundamentally different over populations, however, emotional, and or psychological illnesses comprise a remarkable basis of the predicament globally (Ally & Laher, 2008; Petkari, 2015; Sehoana & Laher, 2015). In addition to that, each culture has its own convictions, traditions, and responses to diseases, including dysfunctional behaviours. Therefore, this understanding contradicts the Eurocentric perspective of psychopathology which is immersed on social inclusiveness that proposes that there is a standard process for conceptualising pathologies and that the symptoms of mental illnesses are comparable over various societies (Bomoyi, 2011; Sehoana & Laher, 2015). Significantly, cultural characteristics affect and influences the way people make meaning of psychological abnormalities, including how people convey emotional distress, and how they respond to such (Petkari, 2015). Moreover, De Andrade (2014) contends that, infirmity and wellness issues are guided by people's background and social variables. The differing comprehension of ailment and wellbeing, shape peoples understanding of issues identifying with psychological wellbeing and maladjustment. Individuals' framework of reference depends on the exchange of social establishments; structures; traditions; and beliefs in a society, and these impacts the comprehension of causality and treatment of illnesses. Consequently, traditional psychology interventions basically focus on the person, where the illness and treatment strategies are believed to be relied upon. Nonetheless, mental distress is innately built within context and the remarkable, social and cultural frameworks that have been created to comprehend psychological maladjustment. Also, societies normally build up their own frameworks of treatment, grounded in indigenous practices (Dalasile, 2007; Nwoye, 2015).

This section presents the current research. Firstly, it presents a foundation that features the vastness of problems identified with psychological maladjustment around the world. Accentuation is put on the issue of universalism of mental illnesses and cultural differences in the manifestation of mental disorders. The research aims, and objectives are then exhibited. The subsequent section outlines and discusses the method of reasoning for the current study. An outline of the whole research is additionally exhibited in this presentation, therefore giving a short overview of what is to be covered in the consequent chapters.

1.2 BACKGROUND TO THE RESEARCH PROBLEM

The formation of Psychology in South Africa was deeply rooted and relied largely on European epistemologies and philosophical orientation (Chitindingu & Mkhize, 2016). Additionally, Psychology as a discipline is for the most part subjected by the estimations of biomedical perspective. The biomedical approach adopts the existence of commonality in human reality, and that individuals are characteristically equivalent regardless of various cultural backgrounds. In this perspective, psychological illnesses are viewed as the equivalent paying little respect to the unique circumstance and realities experienced by individuals (Dalasile, 2007). Consequently, the thought of universalism in traditional Psychology is identified with the supposition that abnormality is encountered correspondingly regardless of the unique contexts and cultures. Nevertheless, the way that we conceptualise and experience psychological abnormalities distinctively in different settings, deems the universal idea of mental illnesses to be incorrect (Dalasile, 2007; Kometsi, 2016). For instance, within the Western structure for emotional wellbeing and illness, the aetiology of maladjustment is considered to have a substance on the individual; or potentially from the individual's biological domain (Ross, 2010). The Western perspectives' premise to focus its aetiological account of mental illnesses on exclusively three conceivable variables of human psychopathology, be that as it may, is deficient when some types of dysfunctions are experienced in Africa. For instance, treating illnesses such as *amafufunyana:* culture-bound syndrome or an expression of schizophrenia in black Xhosa-speaking South Africans (Nwoye, 2015). Furthermore, most of the psychological paradigms or methodologies of psychopathology consider the aetiology of psychological abnormalities to be within individual factors, that is intrapsychic factors are viewed as the main causal source factor, in this way neglects culture to influence the articulation and significance of human behaviour (Dalasile, 2007).

Various studies have recommended that up to 80% of the South African populace use indigenous healers (Ally &Laher, 2008; Cocks &Møller, 2002; De Andrade, 2014; Eyong, 2007; Melato, 2000; Mkhize, 2004; Ross, 2010; Yen, 2000). In light of this reality, there has also been an expanding acknowledgment of the requirement for an increasingly inclusive framework by Western mental healthcare system to incorporate other therapeutic interventions, for example, indigenous methodologies as a secondary to the treatment given to clients. This has been spurred essentially on account of the broadly recognised need to treat patients inside their very own social settings (Mzimkulu & Simbayi, 2006; Shizha & Charema, 2011). Furthermore, there is expanding

literature that contends for conception and acknowledgment of pathology that goes past the Eurocentric conceptualisations. However so, African traditional understanding of illness continues to be under-researched in spite of the immense number of different cultures in the nation. In addition, each culture's treatment intervention should be considered including recognising the socio-cultural factors found in each culture (Sehoana & Laher, 2015). Bomoyi (2011) suggests that the psychological maladjustment interventions should be culturally sensitive and recognise client in their very own specific context. In support of the above suggestion, it is contended that logically significant ways of dealing with distress should be apparent and socially applicable interventions should be utilised. It is along these lines therefore critical to comprehend the distinctive expression and conceptualisation of dysfunctional behaviour over different societies, this will further enable psychological professionals to offer socially able and suitable services to individuals of different societal backgrounds (Sehoana & Laher, 2015). Moreover, the manifestations that people frequently experience; the beliefs that are associated with the symptoms experienced and psychological illnesses, fundamentally varies among and between cultures (Bomoyi, 2011; Dalasile, 2007). In this way, mental healthcare professionals need to take perception of the cultural elements when managing diagnosis and treatment of psychological abnormalities. Additionally, Zondo (2008**)** states that cultural competence includes thinking about individuals' exploratory framework about the causes of their maladjustment; and their cultural premises of what is pathology and psychological well-being.

In the traditional culture, a standout amongst the most revered wellbeing mechanisms is the critical immediacy of indigenous convictions and the utilisation of African treatment strategies in issues of wellbeing and health (Shizha & Charema, 2011). In addition, in majority of African nations, especially in rural zones, indigenous healers are broadly counselled in the look for causes for pathology and illness, and ceremonial practices are mostly performed to support the person who is ill (Bomoyi, 2011; Shizha & Charema, 2011). On the other hand, Eurocentric psychology and psychiatry have, through globalisation and colonialism, forced frameworks of emotional wellbeing consideration and meanings of psychological maladjustment. In doing as such, traditional indigenous understandings and methods of being relating to emotional or psychological well-being have frequently been obscured (Bartholomew, 2016; Mkhize & Kometsi, 2008). Shizha and Charema (2011) contend that biomedical perspectives and indigenous frameworks that fuse profound recuperating; psychological therapy; physiological; and social health interventions play

an essential and huge role in mental healthcare system in Southern Africa. Research studies concerning the understanding of mental illnesses have been conducted, precisely regarding issues related to the cultural and religious perspectives of mental illness (Behere, Das, Yadav, &Behere, 2013; Hwang, Myers, Abe-Kim, &Ting, 2008; Kirmayer& Ryder, 2016; Petkari, 2015). In addition to that, these studies explored problems which are related to awareness, discrimination, and stigma to the understanding of mental illness were also taken to consideration. Given that there is a shortage of mental health research studies and a limited number of studies relating to explanatory models of pathology (Petkari, 2015), it is thus imperative to study the traditional worldview of mental illness and psychological well-being and the traditional aspect of mental health is the other aspect that needs further research, as African ways of doing things plays a significant part to African people.

1.3 PROBLEM STATEMENT

The pervasiveness of psychological abnormalities is intensifying globally, and this record for a huge weight of disorders and inabilities in healthcare services**.** It is perplexing to take note that despite the advancement made in the management and treatment of psychological issue, just a couple of those needing treatment get it (Kometsi, 2016; WHO, 2001). The likelihood of the absence of access to mental services could be because of psychological well-being practitioners not being tuned into how emotional wellness is conceptualised in various settings (Kometsi, 2016). South Africa has over 50 million people and is known for its ethnic diversity (Chitindingu & Mkhize, 2016). The country's cultural diversity continues to be one of its most grounded resources, this diversity results in the nation to being known as the rainbow country (Chitindingu, 2012).

South Africa's assorted diversity is confirmed and acknowledged by the country's constitution. Despite this acknowledgement, the manner encompassing the country's diversity continues to be uneven and distinctively considered, and this is replicated in the incorporation of indigenous knowledge systems, as well as African indigenous modes of being (Chitindingu & Mkhize, 2016). For example, Dalasile (2007) is of the contention that, African traditional frameworks were ignored and viewed as useless and its adequacy viewed as unsubstantiated. Moreover, Nwoye (2015) states that, the Diagnostic and Statistical Manual for mental disorders (DSM) embraced by the Western perspective, is not merely the diagnostic system for understanding people presenting mental health problems, nonetheless there are different understanding that people have of psychological illnesses. De Andrade (2014) argues that the Western and traditional African indigenous paradigms

have distinct assumptions or standpoints on the understanding of illness and health, which may cause a discrepancy between the two perspectives. Furthermore, matters of wellbeing and disease are guided by individuals' contextual domain and the social significance associated to these ideas. Moreover, the varying understanding of illness and health shapes individuals' interpretation of problems relating to health and illness. People's framework is based on the interplay of social institutions; structures; customs; and conventions in a community, which influences the understanding of causality and treatment of illnesses. Consequently, traditional psychology interventions mainly focus on the person, where the illness and treatment methods are seen to be depended on **(**De Andrade, 2014; WHO, 2001).

In South Africa, the responsibility of helping clients and anticipating psychological maladjustment is to a great extent left to mental health practitioners, who cannot help all the clients given the lack of professionals and mental healthcare services (Kometsi, 2016). It is for this reason; Shizha and Charema (2011) assert that a large number of indigenous individuals in Southern Africa, the consulted person continue to be the indigenous healthcare professional. Post-politically-sanctioned racial segregation in South Africa has acquired a heritage of racially biased, divided, and insufficiently resourced mental healthcare (Bartholomew, 2016; Dalasile, 2007; De Andrade, 2014; Kometsi, 2016; Mkhize & Kometsi, 2008; Shizha, 2011). The nation has few mental health professionals and deficiently created resources to administer psychological services as per the requirements of the clients. It is urgent for psychological professionals to be taught about explanatory frameworks of illness and health, since some of their clients may have a different perspective with respect to the causes, nature and treatment of disease as opposed to the western perspective (Kometsi, 2016). In light of this understanding, Zondo (2008) contends that, African communities have been using their indigenous knowledge to conceptualise illness and health, and to find intercession or treatment methods. The comprehension of mental related issues, for example, the determination, cause and treatment are social ideas and, in this manner, reflect the social principles and beliefs of a particular community (Dalasile, 2007; Kometsi, 2016). Indigenous African beliefs and practices which are related to illness and health are widely held by rural communities; even so, people from urban areas do hold these practices and beliefs (Ѐreeman & Motsei, 1992; Bomoyi 2011; Austin, Bezuidenhout, Du Plessis et al., 2014). Evidently so, in deep rural and urban areas, an excessive number of people make use of traditional healers when they have mental health problems and for them, the main health care may be considered

tantamount with indigenous healing**.** And this is particularly so even between individuals who transcendently use western medication, there are instances when the illness is considered to have an African experiential reason, and therefore cannot be treated by western methods of treatment (De Andrade, 2014; Ѐreeman & Motsei, 1992). The traditional African beliefs and practices form a comprehensible system that has sustained individual and social equilibrium for many years. Individuals are shaped by the beliefs and worldviews of the culture in which they have been socialised. Therefore, it is essential for mental health practitioners to be culturally sensitive in their orientation (Austin et al., 2014; Bomoyi 2011; Kometsi, 2016). Indigenous healers are effectively available on the grounds that they regularly live in the same area, and often share a similar culture, convictions, and qualities as the people who use their services (Bomoyi, 2011; Kometsi, 2016; Mkhize & Kometsi, 2008). It is likewise critical to take note of that, the expenses and accessibility additionally assume a substantial part in affecting the decision which clients make when they consult healthcare services, basically, indigenous healers are a mostly the source of healthcare for most of individuals particularly in rural backgrounds (Ѐreeman & Motsei, 1992; Kometsi, 2016). Moreover, Ѐreeman and Motsei (1992)argues that, whether indigenous healers are incorporated into the mental healthcare system, people will keep on finding the professionals who they consider to be the main individuals fit for recuperating them.

According to Nwoye (2015) the Eurocentric Psychology's inclination to expound people exclusively in substantial, physical, or discernible terms should be analysed. The Eurocentric orientation disregards consideration to human spirituality, which is central to African psychology, as it impacts African peoples' wellbeing. Bomoyi, (2011) argues that, the Western perspective knowledge, which predisposed much of traditional psychology claims to be objective and universal, which is the western approach disregards cultural differences that depict a multicultural country like South Africa. Nwoye (2015) contends that the Diagnostic and Statistical Manual for mental disorders (DSM) grasped by the Western perspective, is not merely the analytic framework for understanding people presenting with psychological well-being problems. In light of this contentment, De Andrade (2014) states that that DSM ought not to be merely considered as the framework to analyse psychological illnesses, expressing that the Western and traditional African indigenous paradigms have distinct suppositions on the comprehension of illness and health, which may cause incongruity between the two perspectives. In addition to that, the traditional Psychology diagnostic framework disregards the influence of cultural factors in the aetiology and treatment of

dysfunctional behaviour. Further, these indicative frameworks are inclined by the western cultural elements, values, and beliefs (Dalasile, 2007). It is in this way clear more work should be done to instruct general society about the mental underpinnings of psychological problems and about the estimation of successful mental health interventions (Kometsi, 2016). The determination to educate people about mental illnesses should recognise peoples' explanatory models of illness and as well, psychological practitioners should likewise be sharpened of the explanatory models of illness. In addition, a cooperative energy between practitioners and client's explanatory frameworks of illness and health may persistently fulfil the treatment of clients (Kometsi, 2016). According to Crawford and Lipsedge (2004) there is wide acknowledgment that data and research of explanatory frameworks of mental issues in the developing world has essential pragmatic advantages. Furthermore, different researchers have recognised the significance of making utilisation of indigenous treatments to enhance psychological wellbeing arrangements.

1.4. RATIONALE AND SIGNIFICANCE OF THE STUDY

Petersen and Lund (2011) contend that few research studies in the past that explored the cultural compatibility and benefits of psychological services in South Africa given the diverse cultures and languages. The research findings corroborate that a substantial number of the population endorse indigenous frameworks of illness, that people with extreme psychological illnesses recurrently use both western and indigenous services simultaneously or repeatedly, equally important is that a minority of individuals look for assistance from alternative healers including indigenous healers (Bomoyi, 2011; De Andrade, 2014; Petersen & Lund, 2011). As pointed out previously, in Africa numerous individuals in the rural zones use indigenous treatment when they are ill. This is perhaps the most immediately accessible healthcare or intervention for a considerable number of individuals in rural African communities (De Andrade, 2014; Ѐreeman & Motsei, 1992; Sehoana &Laher, 2015; Shizha & Charema, 2011). To elaborate, in rural South Africa, over 60% of the population seek traditional healing and treatment prior visiting a therapeutic professional and those that look for Western medicinal services, continue to consult an indigenous healer (Shizha & Charema, 2011). In accordance with this understanding, Mkhize (2004) suggests that, dismissing and not recognising indigenous sciences since they exist outside the supposed academic network, is detrimental to a huge number of indigenous individuals. Indigenous healers have been utilising traditional medicine for treating Africans for a multitude of years. Yet, the inescapable idea of

globalisation represents traditional healing and indigenous medicine to dangers of continued marginalisation (Bartholomew, 2016; De Andrade, 2014).

In Southern Africa, the numbers and geological dispersion of indigenous healers give access to healthcare that is not achievable by the constrained extent of biomedicine perspective (Shizha & Charema, 2011). Undeniably, in developing countries South Africa and Ghana included, indigenous medicine will keep on remaining an indispensable and lasting piece of African communities and enduring social healthcare framework (Gyasi, Mensah, Osei-WusuAdjei, & Agyemang, 2011). It is subsequently clear that, the contribution of indigenous healers and medication associations is imperative in the African system for identification; aversion; and treatment of various illnesses (Shizha & Charema, 2011). More importantly, indigenous conceptions of wellbeing and ailment should be consolidated into the training of educational programs of professional psychological workforce (Mkhize & Kometsi, 2004). As it has been demonstrated that innumerable people presenting with emotional distress consult indigenous healers, and this is mostly because of the way indigenous healers are probably going to utilise explanatory framework of illness that are predictable with the client's conception and perceived background of psychological abnormalities (Mkhize & Kometsi, 2004; Thabede, 2008; Yen, 2000). In the same way, communities and Africans all through the world developed frameworks of indigenous medication for ages, and societies discover a large portion of these restorative practices to be respected and reasonable (Gyasi at el., 2011).

Shizha and Charema (2011) posit that Western medicine alone cannot identify; anticipate; and or treat the various parts of profound, psychosocial and mental diseases. In addition to that, the utilisation of indigenous or western therapeutic perspectives with respect to the aetiology, and the people who are probably consulted for psychological services, are regularly affected by contrasting socio-social encounters, ethnic chronicles, and family foundations (Kometsi, 2016; Shizha & Charema, 2011). More importantly, poor organisation and facilities of mental healthcare obstructs the arrangement of psychological services at the primary healthcare level and this is especially so in provincial regions. Perhaps this is because of how psychological healthcare tends to stay low on the needs of most governments in developing nations, South Africa included as contrasted with other different regions of health services (Mkhize & Kometsi, 2004). It must be acknowledged that the two differing approaches to mental illness and health, namely the

Eurocentric and African indigenous frameworks are distinct in cause, diagnosing and treatment of mental illnesses. The African indigenous ways of diagnosis and treatment is extensively approved by the majority, because the premises and principles it yields are compatible with the general population (Bomoyi, 2011; Dalasile, 2007; De Andrade, 2014). In addition to that, the indigenous paradigm seemingly upholds the ideology of Ubuntu which presents the ideas of solidarity; congruity; empathy; regard for others; and human respect (De Andrade, 2014; Mangaliso, 2001).

As apparent from the discussion up to this point, there is a lot to be comprehended about indigenous African conceptualisation of dysfunctional behaviour and the treatment of psychological maladjustment in these societies. Subsequently, indigenous conceptualisation and methods for recuperating illnesses presently seem not to be completely explored and consolidated into the standard understandings of wellbeing and illnesses (Sehoana & Laher, 2015). With these key issues at hand, studies on the contrary outline that around 41-61% of patients with dysfunctional behaviour consult an indigenous healer in South Africa**.** Additionally, indigenous healers are frequently looked for treatment among South Africans as the administrations offered by them are recommended to be more available than those offered by psychologist **(**Sehoana & Laher, 2015; Shizha & Charema, 2011). Equally important, Dalasile (2007) supposes that, the mental health practitioner must understand the explanatory models of their client, and if it differs significantly, they therefore must negotiate between the two models. In support of this supposition, Steward (2008) states that, a cultural approach to mental healthcare is helpful in meeting the therapeutic needs of African people. In the same way, a holistic framework to psychological wellbeing and distress, is ought not to be viewed as a substitute to traditional mental healthcare but become an admissible and undisputed part broader mental health care and of people who need mental health services.

The research study explored the indigenous African worldview of mental illness, psychological well-being, and traditional healing systems amongst the isiXhosa-speaking of Keiskammahoek, in the Eastern Cape. The main sources of the current research study entailed the researcher to interview rural-isiXhosa-speaking participants from area in and around Keiskammahoek in the Eastern Cape Province; and to have face-to-face interviews with IsiXhosa speaking traditional healers from the same area of Keiskammahoek. The outcomes from the exploration of this study will have noteworthy ramifications for psychological professionals in that, exploring the African

origination of illness and health will clarify and outline person's emotional experience of the explored phenomena (Crawford & Lipsedge, 2004). Consequently, a comprehension and conceptualisation of psychological maladjustments held by traditional healers and their treatment interventions for mental illnesses would help plan psychological services in developing countries and might divulge some insight in the discussion concerning the most fitting approach to cooperate indigenous healers (Sorsdahl, Flisher, Wilson & Stein, 2010). Another essential point is that, the data from the current research will help Eastern Cape's Department of Health to plan targeted initiatives for awareness of psychological illnesses and educational projects that will address people in knowledge and demeanours towards psychological instability. Equally so, the research will likewise help South African strategy and mental health professionals in their initiatives to enhance psychological well-being services, because the data from this study will provide the differing understanding and conceptualisation of psychological abnormalities and wellbeing from the perspective of general population and traditional healers.

1.5 RESEARCH AIMS AND OBJECTIVES

1.5.1 AIMS OF THE STUDY

The purpose of the research study is to explore and get an in- depth understanding and perception of Traditional African worldview of mental illness with IsiXhosa speaking people. Moreover, to explore the meaning of psychological well-being within the African worldview and understand the traditional healing systems for mental health problems, amongst the IsiXhosa speaking people of the Eastern Cape. To achieve the research aims, the following objectives in the subsequent subsection were set.

1.5.2 OBJECTIVES

- To explore participants' understanding of mental illness.
- To explore participants' perception of psychological well-being.
- To explore participants' traditional healing systems for mental health problems.
- To demonstrate the role of traditional healers in treating mental health problems amongst isiXhosa speaking of the Eastern Cape.

1.6 RESEARCH QUESTIONS

- What is the participants' perception of mental illness?

- What does psychological well-being mean?
- What is the healing or treatment method(s) of mental illnesses amongst the isiXhosa speaking?
- What is the role(s) of traditional healers in treatment of mental illnesses among the isiXhosa speaking of the Eastern Cape?

1.7 DISSERTATION ORIENTATION

1. **CHAPTER ONE:** The opening chapter introduces the background to this research study by discussing the background and rationale of the study, problem statement and the significance of the stud. Further, the aims, objectives and the subsequent research questions for the study are outlined.
2. **CHAPTER TWO:** The review of literature discussing the relevant topics relating to African worldview of mental illness and health. The section of the research likewise addresses the research problem and questions which result from the gap that was distinguished in past research studies.
3. **CHAPTER THREE:** The discussion of the theoretical positions which underlie the current research study. The two theoretical frameworks which inform the study are traditional explanatory models and framework of African worldview. These frameworks are discussed in detail, a description of how these frameworks are used in the current research is provided in the chapter.
4. **CHAPTER FOUR:** Presents the research methodology of the study. The chapter provides a concise discussion of the research design and the study location of the current research. Further a discussion and outline of the sample technique and procedure; data collection procedure and instrument of data collection; data analysis procedure and the steps of analysing data is provided. Additionally, ethical issues that may arise while conducting the study are discussed, these include but are not limited to informed consent; confidentiality and anonymity; nonmaleficence and beneficence; and reliability and validity.
5. **CHAPTER FIVE:** This section of the research project provides an overview of the research findings, and a discussion of the research findings in relation to the literature review. The tables have been used to summarise the discussion of findings for the current research.
6. **CHAPTER SIX:** This chapter provides a summary, limitations, and recommendations for future research, and the conclusion of the research study.

CHAPTER TWO: LITERATURE REVIEW

2.1INTRODUCTION

The manner for encountering psychological problems is distinctive over cultures and societies, be that as it may, emotional and or psychological problems comprise a remarkable premise of the predicament globally (Petkari, 2015: WHO; 2001). Additionally, cultural qualities influence and impact the way people make meaning of psychological problems, including how people convey emotional distress, and how they experience and respond to such (Abdullah & Brown, 2011; Karasz, 2005). Williams and Healy (2001) present that different research studies have been done (Karasz, 2005; Okello & Neema, 2007; Patel, 1995; Sorsdahl et al., 2010) to perceive the health beliefs and explanatory models apprehended by people experiencing pathology. This section reviews literature directed on the exploration of the African indigenous worldview of dysfunctional behaviour, psychological wellbeing, and traditional frameworks for psychological wellbeing issues in South Africa. The first section of this chapter expounds on the conceptualisation of dysfunctional behaviour and psychological wellbeing in the African indigenous viewpoint; the importance consequently connected to illness is looked at and is outlined in terms of the indigenous African perspective. The consequent section of the current chapter provides a review of African indigenous frameworks of healing with close reference to the procedure of traditional healing; and the classifications of indigenous healers utilising literature available and the role of traditional healers in providing health services outlined in detail. The last section of this chapter is premised upon the legislative issues around African indigenous healing; closely looking at the contentions for and against traditional healing. Along these lines, the chapter reviews the ramifications of fusing and acknowledgment of African indigenous recuperating frameworks, and the conceivable challenges towards the integration of indigenous frameworks of healing, are also evaluated. Furthermore, a dialogue of issues relevant to psychological services in South Africa is provided, by exploring the change and the present condition of psychological health services in South Africa.

2.2 AFRICAN-BASED PSYCHOLOGY

African-based psychology consciously focuses mental examinations in African philosophies; substances; and epistemologies (Bomoyi, 2011; Nobels, 1990). African psychology, as a comprehensive framework, studies the techniques that license for the explanation and release of the spiritual domain by methods for using African traditional religion, in view of the values of

togetherness within the cosmos as a characteristic request of existing. In the same way, traditional knowledge is a philosophy that is profoundly ingrained in the culture and history of people. In addition to that, traditional knowledge shapes the fundamental of the sociocultural; financial; logical; and mechanical identity of such people (Bomoyi, 2011). This section of the chapter focuses on African Psychology or African-based Psychology, which relates to African's perception of illness and health; Indigenous diagnosis; and healing systems. The main thrust of this section is to give and look at elective manners by which psychological sickness can be seen from a social viewpoint outside the structure of Western and sociocultural worldview. The first section provides a discussion of indigenous African worldview as a framework. The key aspects of indigenous African worldview are reviewed. Substantially, a discussion is swerved to bring forth an understanding of African indigenous conceptualisation of mental illness and psychological well-being. A discussion of the idea that people perceive emotional distress or mental illness in relation to their beliefs about the aetiology of distress is brought forward. More importantly, it is profound to provide an outline of such beliefs, as they are fundamental in developing appropriate therapeutic interventions for their reduction and eradication. In connection to that sentiment, a review of the relationship between aetiological and treatment methods is discussed in the last section.

2.2.1 THE INFLUENCE OF CULTURE ON MENTAL ILLNESS

The sociocultural setting where behaviour occurs, distinguishes normal from dysfunctional behaviour, and therefore choosing what is dysfunctional or abnormal is eventually a social judgment that may contrast crosswise over societies (Canino & Alegría, 2008). In addition to that, empirical evidence corroborates that an individuals' sociocultural history impacts and influences every aspect of the illness experience, including the distinct conception of experienced illness (Bomoyi, 2011; Canino et al., 2008; Thabede, 2008; Zondo, 2008). To comprehend the conceptualisation of dysfunctional behaviour in public, it is vital to initially review culture and its impact on the development of psychological maladjustment (Kometsi, 2016), as the diagnosis of psychological instability is given dependent on deviations from the sociocultural; behavioural; and or standards of a culture and community. Subsequently, dysfunctional behaviour is an idea profoundly rooted in culture (Abdullah & Brown, 2011). To substantiate this, Kometsi (2016) suggests that a triangulation of both the Western and African models give the best response for comprehension of culture and behavioural dysfunction problem. More notably, the review of culture comprises a foundation to support the theoretical framework that underpins this research,

by showing that ideas of and frames of mind towards psychological maladjustment are commonly enlightened by the perspectives inside a specific culture (Kometsi, 2016). In addition to that, it is critical to consider the sociocultural context and exposure to social change to create appropriate explanations of pathology (Canino et al., 2008).

A culture which emerges because of human-condition connection refers to the frameworks of beliefs; shared characteristics; and value paradigms that are communal to individuals and that impact their traditions; standards; mental procedures and associations; rituals; and social establishments (Abdullah & Brown, 2011; Kometsi, 2016; Zondo, 2008). Culture is a dynamic and innovative procedure where some parts of which are shared by a group of people because of specific life conditions and narratives. Given the changing idea of our social world and given the endeavours of people to adjust to such changes, culture can best be described as a continuous procedure and a framework or set of frameworks in transition (Regeser Lopez &Guarnaccia, 2000). In the discussion of culture, is infused the concept of cultural norms and it is worth to note that, cultural norms help to figure out what practices to think about as ordinary and which to think about as abnormal, and which may mean psychological maladjustment (Abdullah & Brown, 2011; Canino&Alegria, 2008). In addition, cultural background and values, which differ crosswise, help us to decide a prevalent conviction of a community in regard to individuals with psychological maladjustments (Abdullah & Brown, 2011; Canino et al., 2008).

Cultural and ethnic communities, contrast with respect to practices that are important for ecocultural adjustment and survival (Canino et al., 2008). Given these social contrasts, some researchers follow a universalism paradigm, meanwhile, others adopt a relativism paradigm, on the other hand, others adhere to both universalism and relativism paradigm. Subsequently, there is little accord on the degree to which mental instabilities are universal or the degree to which they contrast on their definition and pattern of syndromes as a result of relevant cultural elements and this discussion proceeds because of the absence of organic markers, loose estimation and the absence of the best quality level for approving most mental conditions (Canino et al., 2008).Nonetheless, literature has reliably validated that in as much as the pervasiveness of psychological instability is the same cross-culturally, however certain disorders and or syndromes may differ**.** Furthermore, empirical evidence proposes that the commonness of some of the most widely recognised explicit clutters of disorders and syndromes, the risk and protective variables

hugely differ over societies, yet co-morbidity and reactions to healing less differ over societies (Canino et al., 2008). In light of this comprehension, Smit, Van den Berg, Bekker, Seedat& Stein (2006) contend that studying mental clutters in various societies is disputable and best clarified by two positions inside the multifaceted psychiatry; these positions are universalistic and relativistic paradigms. Furthermore, Canino et al., (2008) argue that the discussion among clinicians and researchers who adhere to the Universalist versus the relativistic methodology has had long history and proceeds to this date. In this section of the research is a presentation of the perspectives and literature review, which encourage the relativism and universalism paradigm of psychological maladjustments over different sociocultural contexts. Be that as it may, the primary focal point of this current research is to look at and review pertinent literature concerning the dilemma and predicament of cultural universalism and relativism in relation to psychological instabilities, particularly in the South African setting. In conjunction with that, important concepts that are related to the two structures are incorporated into the discussion. Furthermore, infused into the discussion are two important concepts: the etic and emic orientation, which are ideas from phonetics that are concerned with the inception of ideas or concepts.

2.2.1.1 Cultural universalism

South Africa is distinguished by the diversity of societies, and African people embrace different social practices which characterise their identity as a people and as a group (Kometsi, 2016; Thabede, 2008). According to Canino et al., (2008) a number of researchers, especially in the region of the mental study of disease transmission, exclusively adhere to a universalism perspective on psychopathology. The fundamental reason of the universalism paradigm is that mental instabilities and syndromes are universal and have a core feature or manifestation that cluster into the universal symptom manifestations (Canino et al., 2008; Kometsi, 2016). In addition to that, the universalistic position contends that emotional expression is natural. It is the result of a neurophysiological procedure in the limbic framework and a constrained collection of a universal emotional experience. The universalism position is based on biomedicine and emphasises on the categorisation and naming of disorders (Kometsi, 2016; Smit et al., 2006). As to psychological health, the key presumption is that psychological instability is widespread and universal (Kometsi, 2016), and in this manner implies that, what could differ crosswise over societies or subcultures in a culture is the symptomatic indications of the pathology or the threshold of what is viewed as normal versus abnormal behaviour (Canino et al., 2008). Conversely, universalism acknowledges

that symptomatic indication of malfunctional behaviour could differ crosswise over societies, implying that, the same pathology can be manifested distinctively in various societies, but the psychopathology is the same over cultures (Canino et al., 2008, Kometsi, 2016). The confinement of universalism as rehearsed in Western psychiatry is that, it does not give consideration regarding the idea that individual methods for seeing the world and their convictions, impacts, and influences their perception of the world. More so, clarifying dysfunctional behaviour presumptions can be made with respect to the presence of shared traits in the mental make-up of individuals and shared traits in the human experience and conduct (Kometsi, 2016). An orientation that is firmly related to the universalism perspective is the etic approach, and this approach refers to a depiction of phenomena independent of meaning and is practically identical to universalism perspective (Smit et al., 2006).

2.2.1.2 Cultural relativism

It is impossible to think about understanding dysfunctional behaviour outside the sociocultural setting in which it occurs, as behaviour is best comprehended in the setting in which it happens (Kometsi, 2016; Smit et al., 2006). The relativism position declares that emotional articulation is socially built and, in this way, different from a specific sociocultural background and framework. In addition, this is a paradigm that is adopted by ethnographic and anthropological researchers (Smit et al., 2006). More importantly, the relativistic perspective asserts that culture shapes the persons' development; their genetics; and mental development to a certain degree. The principal reason of this perspective is that the social setting shape meanings of normality and pathology; the symptoms and its duration which are required for characterising disorder; the phenomenology of the maladjustment; and the course and reaction to the treatment of the disorder (Canino et al., 2008). In this manner, the guideline of relativism educates individuals that they should avoid making decisions about the lifestyle of others against the standards and estimations of their own sociocultural background and philosophies, however ought to rather build up a comprehension regarding the sociocultural context of the individual concerned. Most importantly, this principle in this manner, repudiate all types of ethnocentrism by recommending that individuals ought to be comprehended in their own terms with no value judgments being made, and without preconceived assumptions being utilised (Kometsi, 2016). Moreover, this approach contends that devices created in one setting cannot catch the eccentric ways that different societies express pathology as it disregards the setting in which an individual life and encounters the world (Smit et al., 2006). For

instance, the relativists contend that DSM excludes the essential social indications and disorders exclusive to a specific social setting, consequently, this results in a classification misrepresentation or evident homogeneity of mental illnesses over societies. Moreover, relativists question the inward brokenness measure of the Universalist DSM-IV approach and express that outside and social elements can shape and decide the side effects related to mental scatters notwithstanding when no interior brokenness is available. Additionally, the relativist questions the attainability of building up a general classificatory framework for all societies. Since such scientific categorisations expand on the presumption that disorders are comparative over societies and what may change is the appearance of the symptoms (Canino et al., 2008). Subsequently, this structure states that mental health professionals ought to not only to attempt to comprehend the shared characteristics of disorders over cultures, however, ought to understand the specific significance of articulations of abnormality in a specific context. More imperatively, to comprehend the individual's experience of emotional distress (Kometsi, 2016). A precedent that best delineates the relativist position is what is referred to by Kometsi (2016); and Spiro (2001), the possession of a stupor which is viewed as obsessive by the social guidelines of the contemporary Western world, yet not by those of a significant part of the indigenous world. An approach that is closely related to the relativist structure is the term emic approach. Emic approach refers to the significance of a specific culture and community associates to a particular thought and is practically identical to the relativist position (Smit et al., 2006).

2.2.2 THE AFRICAN WORLDVIEW

It is critical to first accentuate that the literature reviewed in this part of the research demonstrates that African indigenous perspective on mental health-related issues depends on the sociocultural and clinical reality that is strikingly unique in relation to Western convictions and orientation (Kometsi, 2016). It is in any case, not the aim and objective of this research to dispense and produce a correlation among the African and Western frameworks, as this is probably going to dismantle an apprehension that one is better over the other. The choice to concentrate just on the African indigenous worldview of wellbeing and disease was dependent on the rationale and objectives of this current study. The concept worldview insinuates a conceptual framework which coordinates the basis of the philosophical premises and principles of individuals' convictions. More importantly, it is a theoretical structure through which a group of people account their reality and is the core which administers how individuals conceptualise; reason; feel; and understand their

worlds (Melato, 2000; Thabede, 2008; Vidal, 2008) and this worldview is a comprehensive understanding of reality, which incorporates ancestral spirits, enchantment, and witchcraft (Bomoyi, 2011). African perspective is a tricky concept, difficult to portray, yet is by all accounts the result of African metaphysics; African epistemology; African axiology; African ontology; and African eschatology (Melato, 2000; Kometsi, 2016; Thabede, 2008). It is obvious that conceptualisations of psychological sickness have advanced after some time and without a doubt, the modern world is portrayed by rapid changes (Kometsi, 2016). Nonetheless, Thabede (2008) argues that, despite unique life encounters, African societies have somewhat upheld essential standards of their cultural framework. To illustrate this, all the cultural groups in African culture have value in supernatural beings before becoming Christians and this conviction frames an indispensable part of their perspective of the world.

The sociocultural convictions of Indigenous Africans' are described and characterised by a strong intrapersonal dimension (Bomoyi, 2011; Struthers, Eschiti, &Patchell, 2004; Thabede, 2008; Yen & Wilbraham, 2003). In the indigenous African perspective, a man lives in association with others and should have the ability to find and alter between himself, his family, group and environment, ancestors and nature (Thabede, 2008). In addition, for harmonious balance and soundness, a man must be brought together with their psyche; soul; and body with high regard set on relational connections (Bomoyi, 2011; Ross, 2010). Similarly, African indigenous knowledge considers the interconnectedness of all things, the spiritual idea of beings, collective identity, the comprehensive nature of family structure and oneness of the spiritual, psychological, and physical domain (Nwoye, 2015; Ross, 2010; Struthers et al., 2004; Thabede, 2008; Yen & Wilbraham, 2003). More importantly, Africans have faith in the cosmological solidarity, this conviction spins around extreme cognisance of respect for oneself, others, and nature, particularly the land and water (Bomoyi, 2011). Melato (2000) declares that most Africans believe that their life rests in the hands of the familial spirits; they thank or blame them for both their wellbeing and discontents. The ancestors refer to the dead individuals of a family group, ancestors or *amadlozi* are perceived as supernatural beings who are in the other transient dimension, despite this, people are aware of their existence and the ancestors may occasionally appear to the living (De Andrade, 2014; Melato, 2000; Thabede, 2008). To substantiate this, Thabede (2008) confirms that most Africans understand catastrophe as caused by witchcraft or their ancestors because of their wrath. And De Andrade (2014) depicts how the ancestors can be enraged if their descendants do not perform the

fundamental customs, those identified to birth; marriage; and passing, or if appropriate respect and reverence is not given to them.

African culture is said to be collectivist or communalist in that it is connection based, and the interests of the social gathering are more very esteemed than those of the person (Thabede, 2008; Yen & Wilbraham, 2003). For example, the development of Ubuntu-a basic mankind and thinking about the prosperity of others- is frequently referred to as proof of African communalism that is all-encompassing, common and faithful to tribal customs (Nussbaum, 2003; Yen & Wilbraham, 2003). Besides, Black Africans direct their feeling of self through the African thinking of Ubuntu. Ubuntu is the limit in the African culture to indicate empathy; regard; and being useful to each other. It is the capacity to attest each other as individuals and advance the soul of communalism (Bomoyi, 2011; Ross, 2010; Yen & Wilbraham, 2003; Zondo, 2008). Notwithstanding that, *Umuntu ngumuntu ngabantu* (a man is a man through others) is a thought that is extraordinarily regarded by Africans, particularly by rural African societies (Bomoyi, 2011; Ross, 2010; Zondo, 2008). Moreover, spirituality is the substance of being human and shapes the foundation of the African indigenous paradigm. It is the imperceptible substance that associates every individual to one another and to the creator (Thabede, 2008). In light of this understanding, it is clear that Africans' understanding of self, normality and, abnormality is not comparable with the Eurocentric perspective, which is repetitively inclined to be individualistic (Kometsi, 2016). The Western origination of self is that an individual is reliable of their health, on the contrary Africans will, in general, observe their wellbeing holistically and dependent on extrinsic factors (Bomoyi, 2011; Thabede, 2008). Bomoyi (2011) in this instance describes holism as a conceptual understanding that there is no schism of the spiritual domain and the psyche; implying that the different parts of being including the spiritual, psychological, and physical are solitary and unified. In line with this comprehension, it is consequently fundamental that all mental health practitioners practising within the African context, South Africa included, be very much educated of indigenous African's conception of self, normality, and abnormality. For instance, Steward (2008) contends that a holistic framework is fundamental for understanding emotional wellbeing, as well as to propelling mental health treatment. A part of African indigenous paradigm is the possibility of all-inclusive wellbeing, which images how Africans comprehend themselves in a creative way.

2.2.3 AFRICAN INDIGENOUS VIEWS OF ILLNESS AND HEALTH

It is fundamental to explore and comprehend perceptions about dysfunctional behaviour since this learning enlightens the explicit sociocultural conceptualisation of the aetiology of pathology, including mental distress (Kometsi, 2016). There is tentative evidence in the work of different authors that, mental disorders emerge and are prominent over various social contexts and cultures (Patel et al., 2007; Smit et al., 2006; WHO, 2001). While this is the case, disparities in worldwide predominance rates of the major behavioural dysfunction propose that varieties exist in how these pathologies are communicated and experienced and this fluctuation may to some extent, be clarified and conveyed distinctively in social settings (Smit et al., 2006). More importantly, it is through comprehension of neighbourhood ideas of psychological instability will it be conceivable to devise suitable mediation and interventions to manage psychological wellness. Inability to do as such is probably going to result in lacking comprehension of Africans, with conceivable outcomes of misdiagnosis and misinterpretation of clients experiencing emotional distress (Kometsi, 2016). It is with this reason that the accompanying section of the chapter reviews the literature concerning the indigenous African perspectives on sickness and wellbeing. This review of literature depends on the possibility that the way in which individuals comprehend their tribulations is without a doubt associated with convictions about the aetiology of such distresses, and such convictions are focal in contriving proper helpful procedures for their therapy (Kometsi, 2016, Thabede, 2008). Moreover, a discussion of the connection between aetiological and treatment convictions is included in this section.

Melato (2000) fights that, the African indigenous cosmology of normality and abnormality is situated in the idea of spiritualism. Mysticism proposes a principle that there is an unceasing life where a man continues living as an ancestor. Another fundamental point directed towards this principle, is that the genealogical connects with the living people from the family and goes about as a protector of the entire family and homestead (Thabede, 2008).To illustrate this, infirmity is viewed as a supernatural phenomenon administered by a chain of command of imperative forces beginning with a most extreme deity pursued by spiritual plants and distinctive article, estrangement in these key powers can cause affliction (De Andrade, 2014) Equally important, pathology and normality are perceived in respect of how people comprehend themselves inside their sociocultural setting and conviction framework (Smit et al., 2006). Consequently, the cultural values and principles of a patient are strong determinants of their impression of abnormality and

normality. On the other hand, Èreeman and Motsei (1992) contend that conceptualisation and explanation of psychological dysfunction for many mental health practitioners is that, a conception that has no scientific evidence is pseudoscientific and erroneous. As a result, modern-day understanding of the reasons behind malfunction and pathology are situated in the science body (Bereda, 2009).Even so, tentative empirical evidence suggest that the conceptualisation of mental illness is multidimensional with physical and socio-spiritual features, and it is, therefore, apparent that dysfunctional behaviour cannot be conceptualised without thinking about the sociocultural elements (Austin et al., 2014; Bomoyi, 2011; Chitindingu & Mkhize, 2016; Kometsi, 2016; Thabede, 2008; Zondo, 2008). In the indigenous African perspective, there are ordinary and unnatural explanations behind dysfunction where ordinary causes may include age-related illnesses and mishaps, while the unnatural causes incorporate witchcraft; spirits; ancestors; and the failure to do certain cultural ceremonies and rituals (Bereda, 2009). More importantly, it is imperative to understand that psychological interventions focus and are oriented around how the dysfunction is experienced, complementary to this, the African interventions focus around why a person has been affected, by explaining a cosmological angle with the causation of infirmity (De Andrade, 2014; Kometsi; 2016; Nwoye, 2015). Subsequently, Bomoyi (2011) brings forth the importance of the development and promulgation of mental human services that includes interventions that have an African indigenous orientation. In accordance with this comprehension of indigenous African conceptualisation of normality and abnormality, this section brings forth the key aspects of indigenous illness and health understanding based on the literature considered.

In the African traditional perspective, malfunction including behavioural dysfunction means that there is disharmony or disarrangement in nature; among individuals; and genealogical spirits (Bomoyi, 2011; Kometsi, 2016; Struthers et al., 2004; Thabede, 2008). In Addition, the ailment comes about the conventional breakdown of the body or catastrophe and it is extensively acknowledged by Africans that someone cannot be simply dysfunctional without extrinsic factors. The abnormality is a characteristic of social dramas and a break in the ordinary routine of a persons' existence, changing the internal and external balance from peace and congruity to disorder and desolation (Bomoyi, 2011; Nwoye, 2015). To substantiate this, De Andrade (2014) maintains that in the African indigenous perspective, dysfunction represents individual; relational; and sociocultural domains which are represented by familial, cultural, and social variables; this implies that disease is socio-culturally constructed. Furthermore, in the African paradigm pathology is

understood and conceptualised in unequivocally religious terms, as being caused by spiritual forces (Ѐreeman & Motsei, 1992; Thabede, 2008). Above all, as indicated by the indigenous African perspective malfunction cannot be organised in terms of only the physical or psychological elements, yet rather should be conceptualised also in terms of a coordinated social pattern and along these lines, affliction is as well credited to social disharmony (De Andrade, 2014; Kometsi, 2016; Thabede, 2008).

In the African perspective the predominant point of convergence of life and the objective of a psychologically well individual is to be incongruity with the astronomical forces and the dynamic relationships with other people; spirits; and nature (De Andrade, 2014). For example, Bomoyi (2011) contends that the failure to appease the ancestors may eliminate connections with them and cause disequilibrium. In the same way, in indigenous African communities, wellbeing is a balance in the cosmological and social relations inside the family, society, and with the ancestors. At the point when the mind, body, and spirit are in concordance a person experiences a convergence of being from both the inside and outside world (Dalasile, 2007; Kometsi, 2016; Struthers et al., 2004; Thabede, 2008). In addition to that, psychological wellbeing is a state of congruity between the various dimensions of being from God; the universe of ancestors; people; and the earth (Thabede, 2008). Furthermore, mental prosperity is not simply observed as the nonappearance of disease, it incorporates an individual's ability to work inside their social setting while a breakdown in social relations results to ailment (WHO, 2001). As can be found in several contentions by different authors (Dalasile, 2007; Kometsi, 2016; Struthers, Eschiti, &Patchell, 2004; Thabede, 2008) that mental wellbeing is related with a balanced connection between the individual and nature; other individuals; and their profound world**.** Similarly, psychological wellbeing identifies with congruity in body and mind; and incorporates a supposition of satisfaction with life (Dalasile, 2007; Mkhize & Kometsi, 2008). This conceptualisation of psychological wellbeing is consistent with the meaning of normality defined by the *World Health Organization* (WHO), as more than a lack of disease, and yet a state of complete physical, mental, and sociocultural domains (WHO, 2001).

2.2.4 AFRICAN INDIGENOUS DIAGNOSIS

The clinical or mental diagnosis in the indigenous African worldview refers to determining the aetiology of diseases. In the African paradigm, indigenous healers are usually sought for by the individual or family members of the person who is sick and traditional healers utilise their second

sight to see behind what ordinary people perceive, for them to understand the nature of the pathology is and what has caused the illness (De Andrade, 2014). More importantly, the diagnosis is concerned with answering the questions that relate to what the pathology is; who or what caused it; and why has the individual been inflicted (De Andrade, 2014; Kometsi; 2016; Nwoye, 2015). To substantiate this, Dalasile (2007) and Kometsi (2016) contend that, African indigenous healers are more concerned with the aetiology of the dysfunction rather than symptom groupings when providing a diagnosis. In the African cosmology the diagnosis centres on the individual holistically and relies upon the African belief; which is based on interdependent self which discovers its' reality through others, supposedly broken connections cause pathology (Thabede, 2008; Zondo, 2008). In accordance with this comprehension, Bomoyi (2011) contends that it is essential for psychotherapists to be educated in indigenous knowledge relating to mental wellbeing and pathology, to maintain a strategic distance from misdiagnosis. As corroborated by various authors, that a person who is encountering *ukuthwasa* may be determined to have Schizophrenia and put in a psychological institution since in the process of *ukuthwasa* an individual may show patterns that resemble schizophrenia (De Andrade, 2014; Kometsi, 2016).

The African indigenous diagnosis general looks at the illnesses as a content pregnant with importance and a message this infers that psychological instability is comprehensively interpreted rather than being described as highlighted in the Western Diagnostic and Statistical Manual of Mental illnesses (Nwoye, 2015). Additionally, the diagnosis procedure incorporates the perception of the clients; the clients self-diagnosis; and divination process. It is worth to note that, the indigenous African diagnosis depends upon the indigenous healers' interpretation of the clients' social conditions and through supernatural powers (Nwoye, 2015; Kometsi, 2016; Thabede, 2008). In the same way, African individuals put stock in extraordinary forces (De Andrade, 2014; Thabede, 2008). For instance, divination and witchcraft can similarly represent the presence of dysfunction, as it is acknowledged that spiritual forces can cause illness on account of jealousy and maliciousness; witchcraft is as well recognised to be one of the reasons for pathology (Shizha & Charema, 2011; Melato, 2000; Thabede, 2008). Result findings from the study conducted by De Andrade (2014) suggested that African indigenous healers can diagnose a patient, even in their physical absence when a relative comes to consult. Moreover, the relatives do not describe any of the patient's history and or symptoms. The indigenous healer relies upon their power of divination to analyse the illness and often sit inverse the relatives and make explanations concerning the

patient. More importantly, African indigenous healers use different strategies as oppose to those of mental health specialists to diagnose, these incorporate throwing of bones; counselling with the relatives while the patient remains at home; asking the ancestors and supplication (Kometsi, 2016). To demonstrate this, De Andrade (2014) suggests that African indigenous healers depended vigorously on divination to diagnose and treat illness, this suggestion finds support in the work of different authors. In support of this projection, Dalasile (2007) states that, African indigenous models of healing are a mixture of clients' self-diagnosis and divination and this procedure includes but not limited to the throwing of bones; dream interpretations; and discernment by the indigenous healer.

2.3 AFRICAN INDIGENOUS HEALING SYSTEMS

The author of this current study sees incredible significance in first clearing up various terms before getting into the discussion of African indigenous healing. First and foremost, African treatment is by no means a singular phenomenon, despite that it is frequently alluded to thusly. As suggested by Yen (2000), it is typically heterogeneous and contains a wide and pluralistic scope of specialists and practices. Furthermore, the African indigenous treatment and healing framework differs from the Western methodology in multiple ways (Mzimkulu & Simbayi, 2006). In accordance with this comprehension, Mzimkulu and Simbayi (2006) state that indigenous recuperating focuses around who and not what caused the malady (Kometsi, 2016; Thabede, 2008). The inquiry is chiefly about whether it is sorcery or infuriated ancestors, along these lines, the treatment is likewise concerned about the whole individual and regularly incorporates both close and inaccessible relationships (Bomoyi, 2011; De Andrade, 2014; Kometsi; 2016; Mzimkulu & Simbayi, 2006; Nwoye, 2015; Thabede, 2008). Such treatment regularly incorporates ceremonies including moving and singing in the patient's home while evocating malicious spirits and at the end of the ceremony, is a feast where the certain animals are offered as a sacrifice to appease to the spirits and ancestor and the drinking of traditional alcohol (Mzimkulu & Simbayi, 2006). This part of the section reviews African Indigenous healing methods in relation to issues of illness and health. The literature that is considered in this review is concerned with what is encompassed in indigenous healing and the process of healing on its own. In addition to that, the author discusses how the self is seen and conceptualised in Africa communities, this phenomenon is important as it forms part of how indigenous African healing is performed. Furthermore, a review of traditional healers and

categories of indigenous African healers is provided, with a focus on the AmaXhosa traditional healers.

2.3.1 THE PROCESS OF TRADITIONAL HEALING

The absence of therapeutic understanding of illnesses and Western medicines, it is not appalling that many Africans swung to supernatural powers to explain; translate; and understand dysfunction (Dalasile, 2007). In respect to that, people used traditional knowledge and religious systems to cure and manage their illnesses (Zondo, 2008). African traditional healing strategy is comprehensive and consequently advances the coordination of the mind and body, and the treatment procedure is concerned with every domain and aspect of the individual (Dalasile, 2007; Kometsi, 2016; Mzimkulu & Simbayi, 2006; Struthers et al., 2004; Thabede, 2008). To substantiate this, Dalasile (2007) argues that, a holistic treatment implies a recovering system that can keep up congruity among all domains of a patient's life, and this is conceivable through an appropriate comprehension of indigenous knowledge. More essentially, indigenous African treatment is seen as one which focuses on the spiritual; social; and mental reclamation of the individual (Bomoyi, 2011; Prinsloo, 2001; Struthers et al., 2004; Thabede, 2008). In the indigenous African healing intervention, the traditional healer uses different kinds of treatment methods encompassing interventions with the ancestors and appeasing to them; performing remedy cultural rituals; and herbal medication (Dalasile, 2007; Kometsi, 2016). For example, Mzimkulu and Simbayi (2006) contend that the treatment customs frequently include a community of people coming together, and these people form an essential part of the treatment. In line with this understanding, it is similarly essential to take note that, indigenous healers consistently share a relative history and conventions with their customers (Bomoyi, 2011; Mkhize & Kometsi, 2008). In support of the above discussion, the treatment in the African intervention is consequently administered to re-establish the physical and cosmological congruity that is important for the wellbeing of an individual, by using culturally and traditionally upheld rituals and pharmaceuticals (De Andrade, 2014).

In discussing and reviewing the literature concerning indigenous African healing, it is worth noting how the self is depicted and comprehended in African communities. The self in most African groups is by all things considered in association with others that is with other people; the family; culture; nature; and the ancestors. In this way, in the process of the treatment, these elements are considered while treating clients with African background (Bomoyi, 2011; Thabede, 2008). In

addition to that, a great deal of significance with regards human wellbeing is put on the capacity of the ancestors to look out for their relatives. While this is the case, they are believed by many Africans to cause misfortune and malfunction in the event that they are infuriated (De Andrade, 2014; Nwoye, 2015; Ross, 2010). In light of this comprehension, Mzimkulu and Simbayi (2006) bring forth an argument that with respect to treatment the accentuation is on who caused the pathology, regardless of whether it is relatives or enraged ancestors. The treatment is coordinated to purifying people of shrewdness spirits and protecting them by urging them to do their familial customs.

2.3.2 TRADITIONAL HEALERS

In the African customary societies, the most respected and acknowledged health mechanism is the role played by indigenous healers and the utilisation of African indigenous medication in issues of wellbeing and health (Kometsi, 2016). As indicated by the South African Traditional Health Practitioners Act of 2007, indigenous healers are at present viewed as health experts (Bomoyi, 2011). African Indigenous healer is a person who is perceived as skilled to give health administrations by using distinctive indigenous plants and different procedures in the perspective of the African beliefs; demeanours; knowledge of culture; and religion dominating in that society with respect to physical; mental; social prosperity; and the aetiology of illness (Bomoyi, 2011; Kometsi, 2016; Thabede, 2008). In addition, the indigenous healer generally has exceedingly and relative traditional and cultural knowledge of the socio-cultural setting and background of the client (Ѐreeman & Motsei, 1992; Shizha & Charema, 2011). In accordance with this understanding Dalasile (2007) states that African healers are intended to keep up cultural establishments and to empower their clients to be in harmony with their inner personalities; families and ancestors; and group, convergently this contributes to the clients' health.

According to Mzimkulu and Simbayi (2006) African indigenous healers for the most part find the reason and treatment of emotional distress in the sociocultural elements, in contrast to that the Western intervention which is a more of an individualistic approach that concentrates exclusively on the individual (Dalasile, 2007; Struthers et al., 2004). Another important point is that indigenous African healers are intimately and dynamically involved in the treatment procedure of their clients which often is considered as a client-approach (Bomoyi, 2011; Kometsi, 2016). For instance, indigenous African healers empower their clients to invest as much energy in the process of

healing, this is fundamental for the client to be treated. Complementary to this, the Western healing intervention for the treatment of psychological illnesses has an explicit timeframe to consult mental health practitioners and the client does not invest as much energy in the process of healing. More importantly, in the Eurocentric approach, the clients are the inactive beneficiary of the treatment while this is the case; the African indigenous approach urges the client to partake effectively on the recovering of wellbeing (De Andrade, 2014). Furthermore, African indigenous healers manage the total individual and give treatment to the spiritual; physical; mental; and social manifestations. In addition, traditional healers do not separate the natural from the spiritual; or the physical from the mystic, these domains are considered to be linked (Kometsi, 2016; Melato, 2000; Thabede, 2008).

2.3.3 CATEGORIES OF INDIGENOUS HEALERS

Indigenous African healers are a fundamental piece of the many developing countries and this is particularly so in South Africa (Melato, 2000; Puckree et al., 2002**)** and they offer an extensive variety of guidance; divination; helpful; and different health services to many African descendants (Melato, 2000; Struthers et al., 2004; Thabede, 2008**).** Equally important, African indigenous healers become intimately engaged in each part of the socio-cultural existence of the customer (Ѐreeman & Motsei, 1992; Shizha & Charema, 2011). According to Kometsi (2016), it is worth noting that indigenous healers are not homogenous, they do not all perform comparative roles and or fall in a similar classification. In the Xhosa culture, there are extensively three principal kinds of indigenous healers, these include the Diviner *(Igqirha)*; Herbalist *(Ixhwele)*; Faith healer *(Umthandazeli*); and prophets *(Umprofethi)* may be viewed as a sub-kind of a faith healer (Ѐreeman & Motsei, 1992; Kahn & Kelly, 2001; Mzimkulu & Simbayi, 2006; Yen, 2000). The subsequent section reviews the categories of indigenous African healers, mainly focusing on the three principal kinds of traditional healers in the Xhosa culture.

The principal sort of traditional healer is the Diviner (Igqirha) who refers to the individual known to be a pertinent middle person in managing issues related with illness and wellbeing of many Black Africans (Nwoye, 2015; Thabede, 2008; Yen, 2000). Additionally, the diviners frequently act as a mediator between the person who is debilitated and the ancestors, and regularly the patient's family go to consult with the diviner about the affliction (Ross, 2010; Yen, 2000; Yen &Wilbraham, 2003). According to Kahn and Kelly (2001) diviners are profoundly called to their

calling through their own one of a kind sickness and this is called *ukuthwasa* (Melato; 2000; Kometsi, 2016; Yen & Wilbraham, 2003). This calling as indicated by Mzimkulu and Simbayi (2006) appears as a dream including the presence of an ancestor who advises the person of the desires of the familial shades or spirits to use the person for healing individuals. In addition, when the calling is acknowledged, the person begins the initiation under diviners' direction and the process regularly takes between three and five years. Furthermore, the diviners' training originates from a profound knowledge of the African indigenous sociocultural framework and intervention. More importantly, the diviner has expansive knowledge and understanding of traditional medicine and use supernatural forces to clarify hardship; to treat illnesses and offer the root cause of the dysfunction by appeasing the ancestors (Kahn & Kelly, 2001; Thabede, 2008; Nwoye 2015; Yen, 2000). Equally important, the element that is important to the diviners' work is the intercession of the relationship with *Izinyanya* (shades/ancestors), who are believed to be the cause of the disorder and setback whenever they are enraged (Nwoye, 2015; Ross, 2010). In the African structure, a divination session is based on the premise that the ancestors of both the client and the diviner are present or accessible at any time, if the need emerges in helping the examination for finding the clients' malfunction (Nwoye, 2015; Kometsi, 2016; Thabede, 2008). In light of this understanding, African divination is, therefore, a procedure of learning a disguised aggravation and inviting the ancestors and other spiritual agents to interpret and bring about the understanding of the causes of the illness **(**Nwoye, 2015**).** Furthermore, the process of initiating the diviner includes in addition to other things, the evaluation of the pathology and malfunction; and the treatment of sicknesses (Melato, 2000). In addition to that, sometimes the procedure incorporates the uncovering of herbal medicines to the person chosen by their precursors (Mzimkulu & Simbayi, 2006).

The other kind of indigenous African healer is the Herbalists *(Amaxhwele)* who refer to the indigenous African healers who have broad knowledge about therapeutic herbs (Ross, 2010). In addition to that, herbalists are not necessarily called to their practice unlike the diviners (Kometsi, 2016). Furthermore, herbalists are frequently called traditional doctors; they use African remedial plants; animal parts; prescriptions; and concoction, some of which have protective capacities (Melato, 2000; Kometsi, 2016; Yen, 2000; Thabede, 2008). Therefore, to this degree herbalists share a part of divining, however, their main concern is transcendently with recuperating illness (Kahn & Kelly, 2001). Equally important to note, the training procedure of the herbalist is like the training of western healers, in that the person that is trained embarks on the process by choice and

is trained by a certified herbalist to understand and recognise certain herbs and how they work (Melato, 2000; Mzimkulu & Simbayi, 2006). The third kind of African indigenous healer is the faith healer, who refers to the people who are controlled by the Holy Spirit and can anticipate the future and encourage on the best way to turn away an unfortunate event. Additionally, faith healers are declared Christians who for the most part have a place with one of the Independent African Churches and heal through supplication (Kometsi, 2016). This is particularly so with the Independent Separatist Churches of Southern Africa, regularly called Zionist or African Independent churches, which hold some of the customs, traditions, and paradigm of African communities. African confidence treatment is an amalgamation of African cosmology and Christianity (Ntombana, 2015; Puckree et al., 2002)**.** The spiritual healer is both called and trained, however, in an indistinguishable way to that of a diviner. Additionally, faith healing can be traced to the rise of the Independent African Churches, which separated from the more western-situated evangelist churches (Mzimkulu & Simbayi, 2006). In support of the above discussion, Kahn and Kelly (2001) and Ross (2010) affirms that in South Africa being a Christian does not suggest a break with indigenous African beliefs and rituals. In addition, De Andrade (2014) states that faith healers are embedded in Independent churches and faith healers are seen as unprecedented individuals with insightful and healing powers working from inside African church cosmology.

2.4 POLITICS OF AFRICAN INDIGENOUS HEALTH

There are different contentions and reasons that have been conveyed and offered with respect to why traditional healers are to be or not encompassed in the emotional wellness services (Ѐreeman & Motsei, 1992). Bomoyi (2011) contends that African people have an essentially extraordinary and increasingly holistic origination of illnesses, including dysfunctional behaviours and psychological wellbeing. This conviction alone manages support for incorporating and usage of indigenous African perspective into the psychological human services. More importantly, the lack of restorative and mental workforce in rural communities and indigenous healers appear as promptly accessible and available reciprocal professionals who can provide healthcare to individuals. Therefore, indigenous African healers are contended to give a socially and culturally appropriate and holistic healthcare for many African clients, where psychotherapists and other mental healthcare professionals are not available and accessible (Yen, 2000). Furthermore, indigenous healers are generally referred to as being inevitably capable to comprehend African

clients because they mostly have an African background and are in this manner more qualified for their consideration to healthcare of African descendants (Kometsi, 2016; Thabede, 2008; Yen, 2000). In contrast, the nonappearance of basic analysis of indigenous frameworks of healing in the literature, proliferate the depiction of indigenous recuperating frameworks as enigmatic and inexplicable to people who do not have an African background, this in turn results to conceptions of indigenous frameworks as only for African people (Yen, 2000).

This section of the chapter reviews the African indigenous healing framework for psychological healthcare. The review of literature develops by looking at indigenous healing as a structure for dysfunctional behaviour and wellbeing, subsequently a discussion shifts and outlines the reasons why the previously mentioned frameworks of healing ought to be incorporated into the mental health system. A discussion of the ramifications of incorporating indigenous health framework is overviewed. The first section is finished up by reviewing the differentiating thoughts of traditional healings' incorporation into the psychological health services. Having examined the move towards the acknowledgment and incorporation of African indigenous healing, it is presently relevant to review the present condition of psychological care in the South African context. This section will also look at South Africa's mandate in the provision of integrated healthcare. Additionally, the difficulties identified with these endeavours will likewise be explored and reviewed.

2.4.1 INCORPORATING AFRICAN INDIGENOUS HEALING SYSTEM

The basis for a coordinated effort between indigenous healers and the psychological human services has been recurring in South African literature on emotional wellbeing care in the course of 30 years; however, there is inadequate formal integration effort in the institutional practices (Yen and Wilbraham, 2003). The advancement of African indigenous healing and incorporation efforts with the psychological healthcare is persuaded not just by altruism towards traditional healers and worry for the psychological care of people presenting with dysfunctional behaviour. However, there are a variety of reasons and interests that may lie behind endeavours to collaborate. The vast majority of the literature is uncritically positive about the requirement for some type of joint effort between indigenous recuperating perspective and the emotional and psychological healthcare services (Puckree, Mkhize, Mgobhozi, & Lin, 2002; Thabede, 2008; Yen, 2000).

Bomoyi (2011) states that several studies conducted, and the literature reviewed indicates that many people from various cultural backgrounds were effectively treated utilising African

indigenous interventions. In addition, the Western treatment has been for the longest of time presumed as sublime to alternative forms of healthcare interventions. Nonetheless, it has likewise been recognised that it has been fruitless to remedy other health-related problems**.** Indigenous African healing is a comprehensive and holistic paradigm, that is African traditional healing is not exclusively concerned about physical infirmity only, but as well with the psychological domain (De Andrade, 2014; Steward, 2008; Struthers, Eschiti & Patchell, 2004). In the same way, Thabede (2008) contends that indigenous treatment is particularly utilised and acknowledged for its' successful treatment for such illnesses initiated by sorcery. Moreover, African indigenous healers can help their clients, since they have an over-encompassing comprehension of their clients' frame of reference and lifestyles descendants (Yen, 2000; Kometsi, 2016). Ѐreeman and Motsei (1992) contend that traditional healers are recognised in African communities, since they are increasingly accessible and influential, besides that, an enormous number of African people utilise the services of indigenous healers (Kometsi, 2016).

Bomoyi (2011) contends that African traditional healing is profoundly rooted in African beliefs, and a multitude of African people are of the perspective that, specific afflictions are not regular in any case they are credited to black magic. Additionally, the traditional healer is the main individual who can recuperate the person whose infirmity is ascribed to witchcraft. For the most part, people believe that the individual who is charmed will potentially pass-on if they do not seek the services of an indigenous healer. Additionally, Ѐreeman and Motsei (1992) express that the process of African indigenous treatment is mostly of precedence than Western services for many Black Africans. Along these lines, exploring the African indigenous perspective would unquestionably contribute and afford the necessary fundamental data to psychological care about the treatment that benefits clients with the African background. In addition to that, Steward (2008) is of the contention that consideration of sociocultural practices into the emotional healthcare, can be a method for cementing cultural distinctiveness. Moreover, a numerous number of individuals counsel indigenous healers especially in rural communities, evidently training indigenous healers to comprehend and successfully oversee psychological issues in their societies might increase the use of these services since they are frequently accessed for psychological services (Kometsi, 2016). Melato (2000) declares that African indigenous cultural beliefs and customs are observed in both urban and rural areas; consequently, there is a requirement for such practices and traditions to be

consolidated and catered for in the mental healthcare. The inadequate health resources in developing countries further encourage the utilisation of African indigenous healing as their services are moderately accessible and available in many African communities **(**Gage, 2007; Kometsi, 2016; Wilson, Couper, De Vries, Reid, Fish, & Marais, 2009). According to Ѐreeman and Motsei (1992) indigenous healers are a part of Black Africans culture because they are progressively accessible, as well an enormous number of African people utilise the of indigenous healers.

Ѐreeman and Motsei (1992) contend that there is a need to settle on required and striking choices, one of which is the role of indigenous healers in the mental healthcare system in building up a health policy for a new South Africa. Africans have a significantly different and progressively comprehensive conception of mental dysfunction and wellbeing (Thabede, 2008); this conviction alone bears an avocation for incorporating and the utilisation of this perspective into the emotional and psychological healthcare. In addition, mental clinicians that are trained from a variety of paradigms including the African indigenous paradigm would be enabled to work into and work successfully in different of social settings (Bomoyi, 2011). Furthermore, Melato (2000) declares that African indigenous cultural beliefs and traditions are observed in urban and rural areas, for this reason there is a requirement for such practices and traditions to be merged in the healthcare services. Moreover, Bomoyi (2011) states that it is essential that the alternative methods of healing including the indigenous healing technique be propelled, something that mental health professionals who are skilled in the Eurocentric orientation have hugely neglected to do. Consequently, incorporating African indigenous interventions of healing suggests that indigenous healers become integrated into the primary healthcare services and impart preventive healthcare services to the general population who need their services (De Andrade, 2014). In the same way, consolidating indigenous healing into the mainstream mental care would empower therapists to render mental administrations that would not just meet the mental needs of Africans. On the other hand, their services would be culturally sensitive and appropriate to African communities, which would permit a more diverse and open mental healthcare, where clients are afforded the opportunity to use indigenous healing when they feel the need to do so (Bomoyi, 2011).

2.4.2 THE MOVE TOWARDS RECOGNITION OF INDIGENOUS HEALING

Kometsi (2016) argues that social administrations and policies were exclusively secluded by race or ethnic gathering and likewise the urban vicinities were assembled with resourced services, while the rural communities were under-resourced. In addition, the colonial rule has deliberately disbanded the African culture and traditions to the inconvenience of the Africans and the African territory was not simply appropriated, but the African way of life was strongly influenced by colonial and industrialist improvement. In addition to that, the African culture and beliefs were mocked; removed; and superseded by Western techniques and paradigms (Èreeman & Motsei, 1992; Shizha, 2011; Thabede, 2008).

African indigenous healing has been in use in Africa for many years, conversely, colonialism impacted negatively on the training of indigenous healing as the West sought to dominate the world in all spheres of life (Bomoyi, 2011). In the same way, the suppression of African indigenous healing in South Africa originates back to the Cape Medical Act of 1891(Swartz, 1995; Swartz, 1996). According to the Cape Medical Act of 1891, indigenous healing was not regarded as an intervention for treatment, on the contrary, only allopathic or Western treatment was regarded as a type of healing intervention (Bomoyi, 2011; Phatlane, 2006; Swartz, 1995; Swartz, 1996). This stance and discourse were supported and exacerbated by the British imperial control and civilisation mission and in addition to that, this inclination was increasingly reinforced in Bloemfontein when every single indigenous healer was commanded to stop practicing since their method of healing was considered to be witchcraft (Bomoyi, 2011. Likewise, missionaries had an imperative influence in the repression of African indigenous healing. At the point when indigenous healing was exercised, on each event, the missionaries advised Black communities that traditional treatment was abhorrent and non-Christian and for that reason ought to be discontinued (Ntombana, 2015; Waite, 2000). In light of this understanding, Bomoyi (2011) contends that Africans' healthcare needs must be very much provided for, in light of the fact that for a long time, Africans were denied access to legitimate human services and this should be possible by training mental healthcare experts in a socially and all-encompassing manner.

Èreeman and Motsei (1992) express that several indigenous practices have encountered changes to suit contemporary and technological developments. Melato (2000) contends that there is a need

for pivotal planning of the South African healthcare as an attempt mandated to modify an uneven paradigm to healthcare services, to a progressively comprehensive and unprejudiced healthcare approach. Also, the Centre for Health Policy has required the advancement of a strategy with respect to the role of indigenous healers in South African healthcare services. To substantiate this, van Rensburg (2009) indicates that African indigenous practice has as of late been mainstreamed in South Africa by the declaration of the Traditional Health Practitioners Act no. 35 of 2004. Moreover, various studies have distinguished the role of African indigenous healers just as the requirement for the integration of the training into the psychological health services (Melato, 2000). As a result, a many mental health professionals and authors have asked for progressively joint work among European and Indigenous healthcare (Kale, 1995; Puckree, Mkhize, Mgobhozi& Lin, 2002; Thabede, 2008), the demand is with respect to the recognition that indigenous healers have a vital task to carry out, explicitly in the psychological human services field. In addition, this development would enhance another psychological framework in which the two ways to deal with healthcare would be correspondingly acknowledged (Melato, 2000).

2.4.3 THE CURRENT STATE OF MENTAL HEALTH CARE IN SOUTH AFRICA

In the Apartheid system, the 1974 Health Act and its' 1982 changes limited African indigenous healers' execution of any demonstration identified with therapeutic practices, regardless of these laws, African indigenous therapy continued and operated in both urban and rural settings. In addition to that, it was utilised at all instructive and financial dimensions (Ross, 2010). Moreover**,** the advancement made in the exploration of dysfunctional behaviour and accessible innovations to help this, conceptualising what considers abnormal conduct (or psychological maladjustment) is yet a problem (Kometsi, 2016). More importantly, there is currently no formal enrolment or guideline of the different classifications of indigenous healers in South Africa. It is nevertheless interesting that, while the imperative for incorporation effort among healers and the mental health practitioners has been more than once underlined in the last twenty years there is minimal formal collaboration in South Africa (Yen, 2000). On the other hand, developed nations, as opposed to rural networks in under-developed nations, are for the most part marked by extreme infrastructural underdevelopment and destitution, most mental human services offices and faculty are situated in metropolitan zones. In like manner, poor foundation impedes the arrangement of emotional wellbeing administrations at the essential dimension of consideration and this is especially so in the provincial zones, subsequently, in rural areas, an enormous number of individuals are almost

inaccessible to psychological care. This proposes that numerous individuals with psychological problems are either not seeking mental healthcare, or are making utilisation of other administrations, such as African indigenous healers (Kometsi, 2016).

According to Ross (2010) not long after the *African National Congress* (ANC) came to control in 1994, the administration institutionalised the White Paper for the Transformation of the Health System in South Africa, which perceived that indigenous healers be part of the primary healthcare. On the other hand, indigenous healers are not perceived by the *Health Professions Council of South Africa* (HPCSA) and *South African Medical and Dental Council* (SAMIDC) nonetheless, that has not deterred individuals from using their services; as a result, there is support for the integration of traditional healers into the mental health framework (Fèreeman & Motsei, 1992; Melato, 2000). The White paper for the transformation of the Health System in South Africa, acknowledges that indigenous healers are a part of the main healthcare services, and advocate that the ethical code and guidelines of operation must be delineated for traditional healers, so that they become functional associates in the conveyance of healthcare (De Andrade, 2014 Lund, Petersen, Kleintjies & Bhana, 2012; Ross, 2010). The governments' White Paper on the transformation of the Health System in South Africa expresses that despite that indigenous healers are not at this stage recognised as legitimate public practitioners, they are an integral part of the broader healthcare (Pillay, Marawa & Proudlock, 2002; Ross, 2010). More prominently, the paper stipulates that the guideline and code of ethics for indigenous healers are to be set up to enable the registration procedure (Bomoyi, 2011; Pillay et al., 2002). This acknowledgment is by all accounts in accordance with the proposition by the United Nations' Declaration of Alma-Ata, which explicates the requirement for the training of indigenous healers for their resulting inclusion in the delivery of essential human services in their communities (De Andrade, 2014; Mkhize & Kometsi, 2008).

The government in the year 2007 decreed the *Traditional Health Practitioners' Act* to build up the Interim Traditional Health Practitioners' Council of South Africa; to control the enlistment; training and practice with regards to professionals; and protect people who utilise their services (Ross, 2010). More importantly, the incorporation of indigenous healers would encourage therapeutic; preventive; and promotive healthcare as was prescribed at the World Health Organisation gathering at Alma Ata in 1978 (Fèreeman & Motsei, 1992). Furthermore, Bereda

(2009) affirms that communities have fluctuating insights pertaining healthcare services and individuals who choose to use indigenous treatment sometimes may be regarded irrational, paying little respect to the reason of using the treatment and the value associated with the treatment. In South Africa, there are currently two noteworthy characterisation frameworks utilised by most psychological wellness professionals, these are; the *International Classification of Disease System (ICD),* distributed by the *World Health Organisation* (WHO),and the *Diagnostic and Statistical Manual for Mental Disorders* (DSM), distributed by the American Psychiatric Association. The ICD is predominantly utilised in Europe, while the DSM is utilised in the United States and numerous different parts of the world including South Africa (Kometsi, 2016). It is worth to note that, psychological maladjustment and conduct issues are unpredictably tied to the social world (Regeser Lopez &Guarnaccia, 2000), and with that comprehension, the current study reviewed the literature concerning and closely related to African indigenous healing.

2.5 CONCLUSION

In conclusion the chapter reviewed literature, which was related to the study, it can therefore be concluded based on the literature, reviewed that African worldview of illness and health is different from the Western perspective. firstly, in the way illnesses and health are understood and conceptualised, where any ailment in the African perspective is considered to be a consequence of many and various factors such as a broken relationship with the ancestors; angry ancestors and the treatment of such is therefore considered holistically not only involving the person nonetheless the supernatural beings or god; the family and other related factors. Secondly, the diagnosis procedure is different to that of the Western one. Traditional healers are considered to be the ones who play an active role in this, where they can appease to the ancestors on behalf of the person who is sick the diagnostic procedure is mainly executed to know the cause of the illness.

CHAPTER THREE: THEORETICAL FRAMEWORK

3.1 INTRODUCTION

Each human culture has its' very own social framework(s) for reacting to illness and reestablishing wellbeing to people who are sick. The different social substances individuals have developed, regardless of whether these be as far as values, convictions, labels, dialects, traditions, foundations, and laws have a critical impact in how people function and, thusly, in how wellbeing is characterised. Furthermore, the diverse social conceptualisations of experiences relating to disease and wellbeing imply that there can be no universal relevance of one social human services framework (Sodi & Bojuwoye, 2011). In numerous customary frameworks in Africa, including South Africa, emotional wellness issues might be ascribed to the impact of precursors and bewitchment (Bereda, 2009; Bomoyi, 2011; Sorsdahl., Flisher, Wilson & Stein, 2010; Thabede, 2008), and traditional healers are seen as having the ability to address these causes, however, there is constrained data on their explanatory models and resulting treatment rehearses (Sorsdahl et al., 2010). More essentially, ailment be it physical, mental, and or social is a condition that is experienced by all people, regardless of culture, therefore, this suggests each culture has its own explanatory models for disease and wellbeing. Furthermore, since all societies have their own kind of explanatory models, the African indigenous sociocultural models are essentially of different theoretical perspective of dysfunction and or mental instability when contrasted with the Western theoretical perspectives (Sodi & Bojuwoye, 2011). Moreover, progressively looking into; educating; and rehearses underline the requirement for social competency among human services professionals (Laher, 2014).

In accordance with the learning and mindfulness objectives of social competency; and the objectives and aims of this research, the explanatory models of illness and health will be utilised as one of the theoretical structures that support this research study. The utilisation of this theoretical framework helps in the understanding of conceptualisation of ailment and wellbeing from the African perspective, specifically the Xhosa ethnic group. Upon exploring and understanding Traditional African perspective for dysfunctional behaviour and wellbeing, the consequence of this understanding ought to be the means by which mental human services can be socio-culturally sensitive, to cater for the distinctive psychological necessities of the African people. Equally

important, using the framework of exploratory models to comprehend mental illness and wellbeing is fundamental to understand how African people explain the aetiology of mental illness within their unique contexts. As Kometsi (2016) contends that the implications that ascribe to psychological instability are imperative in forming how dysfunctional behaviour is experienced, communicated, and managed. On the other hand, the framework of African worldview will be used to comprehend and understand illness and wellbeing within the context of African people; this mainly focuses on the utilisation and discourse of the animistic, magical, and mystical aetiological comprehension of illness. In addition, utilising the system of Afrocentric paradigm helped to understand mental illness and psychological wellbeing in the bases of Indigenous African perspective. More importantly, this framework assists to understand how the self is conceptualised within the African setting, which gives a position to comprehend the significance of communalism and relations with nature; other individuals; and the ancestors for the reasons for wellbeing. Notwithstanding that, this perspective provides a discussion of spiritualism as one of the important and essential ideas and concepts in the comprehension of illness and wellbeing with the African indigenous context. The important principles and ideas within the African community are discursively discussed, these include African cosmology; African epistemology; African axiology; and African ontology, these ideas structure and are a part of the comprehension of the Afrocentric perspective and characteristic qualities which are the basis for a decent life.

3.2 INDIGENOUS EXPLANATORY MODELS OF ILLNESS AND HEALTH

Anthropological studies discovered that dysfunctional behaviour or abnormality is understood differently, and consequently mental illnesses are treated differently across cultures**.** Furthermore, meanwhile cultural differences in meanings of dysfunctional behaviour do exist, yet these differences do not foster the contention that psychological instability is altogether socially developed (Williams & Healy, 2001). To substantiate this, McCabe and Priebe (2004) contend that explanatory models of dysfunction may contrast between cultural groups and impact treatment fulfilment and consistency. In addition to that, the research findings from the above-mentioned study suggested that when genetic or scientific and supernatural explanations for disorders were thought about, Whites referred to scientific causes more recurrently than Africans, who referred to supernatural causes more regularly. The understanding and conceptualisation of mental illness might be affected by socio-cultural factors, yet the innate idea of abnormality may compel the

conceivable differences of those translations. Subsequently, while anthropologists recognise the different explanatory models with respect to dysfunctional behaviour, similarities prevail over societies that point to both the impact of culture and the inborn idea of mental illnesses (Williams & Healy, 2001). In line with this understanding, Kleinman in 1978 developed explanatory models out of the analysis of Western diagnosis classifications. He discredits that these classifications are themselves culture-free elements, however, comparatively contends that these diagnostic classifications are explanatory models of Western worldview and culture, and therefore inform an officially existing phenomenon which is dependent on the Western cultural setting. Along these lines, sickness is viewed as a sociocultural phenomenon. Furthermore, it is worth noting that social experiences contrast between communities; cultural groups; practitioners; and even people, consequently these distinctions may influence the manner by which people consider and respond to disorder, alternate and assess the viability of the medicinal services accessible to them. Equally important, explanatory models were also created to contrast the frameworks of clinicians and clients, this was grounded on the reason that it is imperative to inspect the relationship and outcomes of the relation between the clients' thoughts; their health issues; and the thought of their healthcare professional (Kometsi, 2016). To substantiate this, Petkari (2015) posits that indeed, clients and helpers establish their own explanatory models for psychological maladjustment considering their cultural knowledge, and the disharmony between those models may negatively affect treatment sought by the clients. For instance, clinicians and clients may have different beliefs and values, and this affects the process of psychological services that will be rendered; and the healing therefore.

According to Williams and Healy (2001), the explanatory models presume that people construct the world in which they live in and through these constructs they make sense of and understand the social world; such constructions are self-sustaining and self-renewing. The term explanatory models (EM) refer to the person’s perception of the nature; the aetiology; and the consequences of their problem, as well as their help-seeking preferences (Kometsi, 2016; McCabe &Priebe, 2004; Petkari, 2015; Sorsdahl et al., 2010). Furthermore, explanatory models give a structure and foundation to look at how abnormality is theorised or perceived; the persons’ reaction to illness; and from where treatment is sought. Medical anthropologists used these approaches to grasp the essentialness of symptoms; their aetiology; onset; possible course; seriousness; and most fitting form of treatment (Charles, Manoranjitham& Jacob, 2007). In addition to that, Kometsi (2016)

states that help-seeking; adapting to the dysfunction; compliance to the treatment; and clients' satisfaction of the treatment is considered as different parts of human conduct that are as well affected by explanatory models. Moreover, explanatory models are normally a mixture of emic and etic perspectives which include ethnocultural; individual; and distinguishing convictions and segments (Charles et al., (2007). More importantly, Melato (2000) contends that explanatory models are an establishment of indigenous African cosmological, religious, and social perspectives of dysfunction and health. Additionally, explanatory models of illness and health are theoretical frameworks for understanding illness and health within the context of the people being studied and are frameworks for understanding the causes which people attribute to illness. Equally important, explanatory models are not stable and unchanging, rather recurrently eccentric, alterable, perpetual, and intensely impacted by both a persons' identity; the therapeutic context; and sociocultural elements. In addition to that, an individual's cultural attributes are again not rigid or unchangeable, but rather perpetually changing and influenced by social; religious; educational; and political components (Charles et al., 2007; Petkari, 2015).

Social construction frameworks, specifically the explanatory models of psychological instability, are important for this current study to expand comprehension of individuals' consciousness of and convictions about dysfunctional behaviour. Most importantly, the explanatory models of disease immensely help individuals to adapt to and understand a sickness as a social reality and experience. Substantially, explanatory models clarify and impact the significance and desires that individuals have about a specific ailment (Kometsi, 2016). According to Williams and Healy (2001), the majority of cultures and communities have set up structures for the understanding of aetiology; symptoms; and treatment of the ailment, where these are deliberately characterised as the framework they might be viewed as a folk illness. However, this does not prevent the truth from claiming the experience of that it may likewise be viewed as a disease by mental health professionals yet essentially portrays how public perceives and understand the phenomena. On the other hand, Kometsi (2016) asserts that it is imperative to take note of that, distinctly from being socio-culturally developed, explanatory models of sickness are as well impacted by other contextual elements, these include but are not limited to level of literacy; social and economic status; occupation; ethnicity; religious connection; and prior experience with disease and healthcare.

3.3 THE FRAMEWORK OF AFRICAN WORLDVIEW

In this current study, the concept African worldview; Afrocentric; African-centred or Afrocentric worldview are used interchangeably and are regarded as synonymous. Furthermore, this worldview in this setting is characterised and considered as the manner by which Africans see their universe, which thus, impacts their lifestyle and how they conceptualise illness and wellbeing (Kometsi, 2016). The framework of African worldview is a conceptual framework through which people identify with and is the primary determinant of how they see, think, feel and experience their universe (Mkhize, 2004). A worldview refers to the way a specific community of individuals understand themselves, their universe (cosmology) and their profound issues and it is a holistic view of reality which includes ancestral spirits, magic, and sorcery (Bomoyi, 2011; Melato, 2000; Mkhize, 2004; Kometsi, 2016; Thabede, 2008). Furthermore, the concept worldview alludes to a conceptual framework which directs the philosophical premises and standards on which individuals' convictions are based and shaped. According to Melato (2000), African worldview is a tricky concept, hard to characterise, yet is by all accounts the result of African metaphysics; African epistemology; African axiology; African ontology; and African eschatology. Additionally, the Afrocentric perspective has an exceptional effect on the understanding of mental illness and health. Thabede (2008) argues that the advancement of the term Afrocentricity must be credited to Asante (1987) which he characterised as actually placing African culture at the focal point of any examination which also includes exploring and studying African individuals. Furthermore, this viewpoint enables Africans to be subjects of verifiable encounters instead of articles on the edges of Europe. Afrocentric alludes to a thought and viewpoint which holds that Africans can and should see, contemplate and explore, translate and relate with other individuals; life and universe; and reality from the vantage purpose of African individuals instead of the point of view of European, Asian, or other non-African individuals. This implies that African people should perceive a phenomenon from a stance of African perspective which is informed by African culture.

The Afrocentric perspective is important in the understanding of psychological instability and health, this framework is all-inclusive and has important concepts and components which are inevitable in the discussion and understanding of the indigenous African worldview in relation to health and illness. The primary standards of the African-focused perspective are: the

interconnectedness of all things; the profound idea of people; aggregate individual personality, the group or comprehensive nature of family structure, the interrelation of the brain, body, and soul; and the estimation of relational connections (Nwoye, 2015; Thabede, 2008; Yen & Wilbraham, 2003). The African ontology considers people to be a collective whole, that is a person cannot be considered to live in isolation, however, should be considered based on interpersonal dimension. In African ontology, much effort is focused on communalism; interdependence; and connectedness and it recognises that everyone has a spiritual dimension (Bomoyi, 2011; Kometsi, 2016; Thabede, 2008). Further, in the African culture epistemology is recurrently about the matter of what establishes knowledge, therefore in this way, indigenous African epistemology alludes to a sociocultural groups' method for philosophising knowledge. In addition, African epistemological position states that there are distinctive methods for perceiving experience and that learning is gained through everyday life encounters. On the contrary, the Western epistemology postulates that learning originates from scientific body of knowledge and empirical evidence (Kometsi 2016). In line with this understanding, Melato (2000) argues that a closely related and important concept which is inherited to the African epistemology of health and illness is spiritualism. Spiritualism refers to the belief that there is life after death where a person continues to live as an ancestral spirit. More importantly, Kometsi (2016) argues that indigenous African epistemology develops out of ancestral knowledge that is profound and exists in the dreams and visions; songs and dances; and the supplications of indigenous individuals, and this infers that indigenous knowledge is lived, experiential, and established learning.

In the same way, African cosmology is concerned about the profound world and the powers that play in it. Additionally, African people enormously consider supernatural causes as the clarification for everything (Thabede, 2008; Kometsi, 2016). For instance, Melato (2000) contends that animistic theory ascribes sicknesses to the conduct of an extraordinary being, for example, God or spirits. Notwithstanding that, Thabede (2008) asserts that all ethnic groups had and still have an indigenous name for a Supreme Being. In the Xhosa clan the being is referred to as *Qamatha*, and among the Zulu is called *uNkulunkulu* or *uMvelingqangi* (Kometsi, 2016). More critically, the African idea is progressively involved; idiosyncratic; sentimental; and expressive, and yet the Western idea is essentially rational; and without expressive and emotional substance (Thabede, 2008). Furthermore, numerous African people have a belief that ancestors shield them

from abhorrence and that the ancestors do not cause ailment out of perniciousness, in any case, it is viewed as the blame of the individual who has ignored or neglected to pursue the guidance from the predecessors (Crawford &Lipsedge, 2004; Melato, 2000; Thabede, 2008), and they rest their life in the hands of the familial soul, that is the soul interfaces with the living individuals from the family and goes about as a defender of the family and residence all in all (Melato, 2000). This is evident in the findings of the study conducted by Crawford and Lipsedge (2004) and Dalasile (2007) that performing certain rituals for the ancestors is important including making sacrifices of animals such as goats, cows, and chickens. Closely related to the concept of ancestors and God are witchcraft and sorcery. These concepts are both believed to be capable of bringing about disease and death (Bomoyi, 2011; Shizha & Charema, 2011; Thabede, 2008). For instance, Melato (2000) argues that magical theories consider the illness to be a result of stealthy actions of a malicious person who inflicts pain or harm on their victim by using magic and sorcery or witchcraft is mainly used to bring about a disorder. To validate this, Laher (2014) states that enchantment is normally used by a noxious alchemist and is in this way considered black magic. Typically, the malignant sorcerer will get help from the noxious spirit or supernatural creatures. In addition to that, the witch normally causes disease or disaster by immediate or secondary techniques. Moreover, misfortune is often attributed to witchcraft or distracted relation with ones' ancestors. Lastly, the other perspective to the aetiology of dysfunction in the African culture and Afrocentric worldview is mystical theories, this theory assumes the disorders to be a consequence of an act or experience of the afflicted individual (Melato, 2000).

3.4 CONCLUSION

In the above chapter, it can be concluded that all the above African indigenous explanatory theories of illness and health (the mystical, animistic and magical theories) are the establishment of traditional African cosmological, religious and social philosophy of wellbeing and sickness. In South Africa patients and clinicians originate from various social foundations, and these contrasting perspectives regularly bring about clashing desires for treatment and results. In this manner, utilising explanatory models as one of the theoretical structures for the present research gave a method for crossing over social contrasts between patients and clinicians with contrasting cultural backgrounds and gave methods for spanning reasonable contrasts and advancing the empathetic and therapeutic relationship. Mkhize (2004) contends that it is illogical to solely

explicate mental health needs and experience of individuals with specific reference to philosophical frameworks imported from the West in developing social worlds. This is especially pertinent in South Africa, where most of the patients originate from assorted social foundations yet psychological instability and its categorisation in formal human services, has a Western premise. Hence, understanding the peoples' explanatory models in connection to psychological wellbeing is valuable in developing and advancing better psychological services. More so, explanatory models (EM) were used in the current research to actualise an ethnographic approach in the clinical picture. It can be contended some of the traditional explanatory models or paradigms are not scientific or do not form a coherent scientific basis, however, these theories are essential in understanding indigenous explanations of illness and health (Melato, 2000). The abovementioned frameworks were used to understand the profound issues of mental health Amongst the IsiXhosa speaking people of the Eastern Cape. In addition, to understand how the individuals within the Xhosa ethnic group view their experience of mental illness and health. The two theoretical perspectives were used to understand how the participants ascribe the aetiology of illness and thereof the treatments sought. Thabede (2008) argues that individuals do not see things similarly, and the manner in which they see things is reliant on their social convictions and the world is distinctively characterised and indigenous African theories usually ascribe aetiology of illness to individual, environmental or social, and supernatural forces and powers.

CHAPTER FOUR: RESEARCH METHODOLOGY

4.1 INTRODUCTION

Neuman (2011) argues that, research cannot be conducted without making use of a research method. The purpose of using a research methodology is to guide a researcher to be ethical, objective, and unbiased during the research study. The current chapter of the research project presents the research design of the study and the research method that was followed while conducting the study. The first section of the study provides a discussion of research design, bringing forth an understanding why was qualitative approach chosen and was considered the most appropriate approach for the study. This will be followed by a section that gives a precise overview of the study location were data was collected, which is Keiskammahoek of the Amathole District in the Eastern Cape Province of South Africa. Subsequently, a discussion of data collection procedure and research instrument used to collect data is provided. A discussion of the sample and sampling procedure that was used to select the participants of the study is as well provided and a description of research participants is precisely outlined. The section that will follow thereafter is the chapter that provides a clear discussion of data analysis method that was used to analyse data, and subsequently the steps followed to analyse data as suggested by Braun and Clarke (2006). The last section of the chapter provides a discussion of ethical considerations that were taken into consideration meanwhile conducting a study. These ethical issues are discussed in detail and how these were dealt with before and meanwhile conducting the current study, these include but are not limited to informed consent; confidentiality and anonymity; non-maleficence and beneficence. Additionally, a precise outline of how entry into the research location was gained is as well provided.

4.2 RESEARCH DESIGN

There are different research approaches namely; quantitative, qualitative, and mixed methods. A research approach is sometimes referred to as a research design by other authors. In this regard, these will be used interchangeably in this current research. A research design is conceptualised as a conceptual framework in which a study is executed, and it establishes an outline of data collection technique and data analysis method for a research study (Kothari, 2004). Kometsi (2016) suggests that a research design gives a vital background that helps to link the research questions and the

implementation of a study. The purpose of a research design is to outline preliminary abstract of methodological issues that are considered in the design of a research. Each research study is different, thus the way in which a study is executed is different. In addition, Kothari (2004) suggests that, a research design that reduces bias and enhances the reliability of the data that was gathered and analysed can be viewed as a sound research design. Furthermore, a design which produces data and gives a chance to considering various parts of a phenomenon can be viewed as the most suitable and proficient structure in regard of many research issues. According to Kothari (2004) in exploratory research, the real accentuation is finding the philosophies and understandings of the issue at hand (Blanche, Durrheim& Painter, 2006). As such, the research design that is mostly suitable for such research studies is a design that is adaptable enough to give a chance to reflect various parts of a research phenomenon to be studied. Moreover, a research design suitable for a specific research issue often includes considering certain factors. For example, the methods for getting data; the aims and objectives of a study; and the nature of the phenomenon to be researched (Kothari, 2004), and in the current research the research method employed is a qualitative research design. Willig and Rogers (2017) argue that qualitative research design in Psychology involves the opportunity to explore and have access to human reality in detail. Furthermore, a qualitative research design affords the researcher an opportunity to define intimate facets of the individuals' worlds (Boeije, 2010; Bomoyi; 2011; Brinkmann & Kvale, 2005). For the above-mentioned reasons, qualitative research design was considered by the researcher the most appropriate design by which to study the phenomenon.

The qualitative research design allowed and enabled the researcher to explore conceptualisation and experiences of mental illness and psychological wellbeing within the context of Xhosa people from Keiskammahoek, in the Eastern Cape Province. As suggested by Neuman (2013) qualitative research strategy empowered the researcher to find and reveal the significance of the research query, as the researcher intimately interacted with the participants when the individual interviews were conducted (Bomoyi, 2011). Furthermore, the flexibility in qualitative research design encouraged the researcher to continuously focus throughout the study and the researcher became very mindful of new understandings during the process of data collection. As contended by Kometsi (2016) that different research designs are most appropriate to answer various types of questions. Then again, the choice of which research design to use is generally informed by the

research questions and the kind of data the researcher is looking for. For this research, the design that was chosen was guided by the kind of dataset that the researcher wanted and by the research questions that were formulated. The research design that was used in the study enabled the researcher to outline Xhosa peoples' conceptualisation and perspectives of traditional African worldview relating to mental illness; psychological well-being; and traditional healing systems for psychological problems.

4.3 THE STUDY LOCATION

There are few studies conducted in Keiskammahoek area, nonetheless there is a study that was conducted by Nguyen (2004) in the Keiskammahoek area. The study was related to observing and documenting a picture of mental healthcare in a rural setting, and recorded views on mental illness from the perspective of nurses, psychiatric clients, and a traditional healer. In the observation, the researcher found that there are many psychiatric patients in Keiskammahoek who are not currently receiving treatment and often are found loitering along the road. Furthermore, the data indicated that there is not a single psychiatry healthcare available for the entire Keiskammahoek area. However, there is one nurse, the coordinator of psychiatric care, who acts as the main link between all the psychiatric clients in the community and the hospital (Nguyen, 2004). The current study, as recommended by Nguyen (2004) explored the Indigenous African worldview of mental illness, psychological well-being and traditional healing systems amongst the rural Xhosa people of the Eastern Cape to get a full conception of the phenomenon. Keiskammahoek was the chosen study location for the current research.

The research was conducted in Keiskammahoek, in the Eastern Cape Province. Keiskammahoek, also called Qobo-Qobo in IsiXhosa, it is a small settler village in the foothills of the Amatola Mountains, located about 50km from King William's Town and 32 km Southwest of Stutterheim, at the confluence of the Gxulu and Keiskamma Rivers. Keiskammahoek became a village after 1853 and attained municipality status in 1904. The main languages spoken in Qobo-Qobo are isiXhosa and Afrikaans. Keiskammahoek serves a large rural community with extensive unemployment problems; service infrastructure; and lack of resources including but not limited to healthcare resources.

4.4 SAMPLE AND SAMPLING

4.4.1 DESCRIPTION OF PARTICIPANTS

The current study made use of purposive sampling to sample set one participants (general public), and this was not only based on the accessibility and willingness to participate in the study, however, the researcher sampled participants that were representative of the population of interest and those who met the criteria and objectives of the research study. Secondly, snowball sampling was used to sample set two participants which were Xhosa traditional healers. The selection of participants was based on purposive sampling of rural Xhosa people and snowball sampling of Xhosa traditional healers, of the Eastern Cape, both females and males. The overall sample size of the current study was eight participants, with five participants in set/group one and three participants in set/ group two. The target population and or sample of the current study were Xhosa people between 35-60 years of age with legal residence with the Keiskammahoek Amathole municipality, the Eastern Cape Province. The sample was drawn from areas in and around Keiskammahoek, Eastern Cape. The researcher went to the central business district (CBD), including the surrounding community halls; clinics; hospital; and government departments in Keiskammahoek to recruit the prospective group one participants for the study. Also, the researcher made use of posters to inform the target population about the research. On the posters, the information of the researcher was made available for those people who were interested to participate in the study. For group two research participants the researcher relied on referrals by participants and other members of the community to recruit Xhosa traditional healers.

4.4.2 SAMPLING TECHNIQUE

A sample strategy is a fixed design for finding a sample from a target population. Neuman (2013, p.247) defines a population as the "abstract idea of the large group of many cases from which a researcher draws a sample and to which results from a sample are generalized". In addition, a sample design introduces a procedure a researcher would implement in choosing items for the sample (Kothari, 2004). Accordingly, there are various sample strategies from which a researcher can choose from. Nevertheless, some of the sampling techniques are comparatively more precise and less demanding to use than others. Moreover, a researcher must select a sample design that will be dependable and fitting for their research study **(**Kothari, 2004). In addition to that, in sampling, a few cases are selected and are examined in detail, and then the information gathered

from the sample is used to understand the larger population **(**Kothari, 2004). The current study made use of a mixture of two sampling techniques, namely purposive and snowballing sampling techniques. The main reason behind using two different sampling techniques was that, the research consisted of two different sets of participants, which both contributed significantly to the aims and objectives of the study, and further gave in-depth information regarding the research questions. A qualitative research design entails the importance of depending on small scale samples; the main reason is to direct manageability of the detailed data collected and satisfactory interpretation and efficient analysis of findings (Anderson, 2010; Melato, 2000). Further Kothari (2004) suggests that a sample size should not be too large or too small, however, it should be ideal, and an ideal sample is the one that satisfies the necessities of competence, representativeness, reliability, and plasticity of a research study. In the current study the number of participants or the sample size of the research was guided by data saturation, this was when the researcher got similar kind of responses during data collection from both sets of participants, consequently data saturation was reached, and the sample size was therefore determined.

In this research study, group one sample of Xhosa people was drawn from the larger population of Keiskammahoek using purposive sampling technique. As described by Neuman (2013) purposive sampling also referred to as judgmental sampling, is a non-random or non-probability sampling technique usually used in exploratory research in which the researcher employs differing techniques to find all possible participants and difficult to reach population (Bomoyi, 2011; Neuman, 2013; Tongco, 2007). In addition, Kothari (2004) argues that non-probability sampling method is a sampling technique in which items for the sample are knowingly chosen by the researcher and the decision about the items for the sample stays preeminent. That is, the researcher purposively draws a certain unit of the target population for establishing a sample, based on the small figure that the researcher selects from a tremendous one and that will be representative of the whole target population. Purposive sampling was used to sample amaXhosa participants, because this technique was considered the most suitable sampling method to draw exclusive participants that were particularly informative and form part of the knowledge source for the study. Bomoyi (2011) suggests that, purposive sampling assures that research participants are studied in their typical contexts which are archetypal of their interest, and this increases the possibility of gaining relevant data. Furthermore, in the current research snowball sampling technique was used to sample set two participants which were Xhosa traditional healers. Snowball sampling is defined

as a non-random sampling method, were the researcher starts with one participant and after relies on the referrals and on information about interrelationships from a participant that finds other suitable sources or participants, and the procedure continues until all the suitable participants are reached (Neuman, 2013). The participants for both sets of groups were females and males, were group one included two male and three female participants, and group two comprised of one male and two female traditional healers.

4.5 DATA COLLECTION METHODS

4.5.1 PROCEDURE OF DATA COLLECTION

When the researcher determines data collection strategy to use for the study, the researcher should remember that there are two kinds of data in Social Science, namely the primary and secondary data. In addition, the researcher should also remember that, the strategy of collecting primary and secondary data vary accordingly (Kothari, 2004). The current research used the primary data method to collect data. It is important to note that, the procedure of data collection started after getting permission and ethical clearance from the University of Kwa-Zulu Natal's Humanities and Social Sciences Research Ethics Committee on the 19th of December 2018.

There are various types of data collection techniques such as questionnaires; focus groups; interviews and many others that researchers use depending on their research design and the appropriateness of a data collection method. In light of this, the current research used face to face interviews as a data collection method for this study. As suggested, individual interviews entail an interviewer asking questions, normally in personal interaction to the interviewee or participant. In depth interview method is a data collection tool that is intended to discover the fundamental reasons and needs of a participant, such interview strategy is used to explore the desires, requests, and feelings of participants about a phenomenon that is being researched (Bomoyi, 2011; Kothari, 2004; Matabane, 2015). Moreover, Kometsi (2016) states that the interview strategy is a data collection tool that provides the researcher with descriptions, representations, manuscripts, which the researcher then transcribes and analyse, and then writes a report which is closely related to the research interests. The interview technique has more adaptability as it affords a chance to reorganise the interview questions, particularly in instances of unstructured interviews. However, this strategy is comparatively more time consuming when the sample is large (Kothari, 2004). In addition to that, the researcher should arrange in advance and should completely understand and

know the problem that is being researched. In line with this understanding, the current research made use of in-depth face to face semi-structured interviews with open-ended questions for both sets of participants, to explore the meaning and understanding of mental illness within the indigenous African worldview of Xhosa people of the Eastern Cape. The interview strategy of data collection included oral-verbal questions and answers, this data collection technique was utilised through in-depth face-to-face interviews and was administered and directed by scientific ethical principles.

The individual interviews that were conducted were guided by the interview schedule, *See Appendix 3(a*), that was formulated by the researcher after a thorough literature review was conducted. Primarily, effective interviews entail appropriate understanding of and a relationship with participants that would enable and empower free and authentic replies from research participants (Brinkmann & Kvale, 2005; Kelly, 2006; Kothari, 2004). Kothari (2004, p.119) suggests that the "interviewer must know that ability to listen with understanding, respect and curiosity is the gateway to communication, and hence must act accordingly during the interview". The use of interviews as a tool for collecting data afforded the researcher many benefits, as proclaimed in-depth interviews afforded the researcher a possibility to reach rapport with the participants and afforded an opportunity to intimately know the research members (Kelly, 2006; Melato, 2000). Furthermore, the interviews permitted the researcher to probe for clarity on the answers given, thereby providing more relevant information, and this helped the researcher to get more insight into understanding indigenous worldview of traditional healing methods for mental problems amongst the Xhosa people.

The individual interviews were audiotaped and transcribed verbatim for the purposes of data analyses. The permission to audiotape the interviews was sought from each research participant prior data collection process began, *See Appendix 1(a)* attached in the appendix section of the research. The researcher used open-ended questions to allow the participants to answer in detail and to be flexible in their responses, thereby prompting them to expand beyond yes and no answers. The interviews for each of the participants depended on the length and depths of the interviewee's responses, which was approximately 30-60 minutes for each participant. Additionally, the interviewees were probed by the researcher when it was necessary to do so, for further information about a phenomenon which was not understood**.** Probing was utilised to direct the discussion

towards achieving the objectives of the study and to increase the quality of the participants' answers to improved and comprehensive answers (Blanche et al., 2006).

4.5.2 CHALLENGES EXPERIENCED DURING DATA COLLECTION.

When data was collected there were unanticipated and inevitable challenges that the researcher faced. Given that all the participants agreed that the researcher uses their homes to conduct the interviews, the researcher asked them to use a quiet and more conducive environment were the interviews will not be disturbed. Nonetheless, there were few cases were the interviews were interrupted by noise considering that the participants live with their families. The rationale behind using participants' homes was to make them more comfortable and calmer, this helped them to respond in a more concentrated and authentic manner. The other challenge that was experienced during data collection was that some participants would haste in their responses because they had other commitments and everyday responsibilities they had to do; however, the majority of participants were more cooperating. The participants were made aware before the interview that they are allowed to respond in any language they feel comfortable with, related to the issue of language. Another challenge was that, since all the interview questions and the entire interview were in English, some of the participants asked that the researcher phrase and ask the questions which they do not understand in isiXhosa language. This was nonetheless not much of a challenge, because the researcher utterly understood IsiXhosa language and it the researchers' mother tongue.

4.6 DATA ANALYSIS

Thematic analysis is an essential technique for subjective examination because it gives researchers the fundamental skills that are valuable for directing numerous different types of qualitative research. In as much as thematic analysis is an inadequately outlined technique and occasionally recognised method. Nonetheless, it is a generally utilised qualitative strategy in and outside Psychology discipline (Braun & Clarke, 2006).The current study used thematic analyses to analyse data. The procedure of thematic analysis in qualitative research includes sorting-out and depicting your informational index in rich detail and further translates different parts of the exploration or research (Matabane, 2015). As argued, one of the advantages of thematic data analysis is its adaptability (Bomoyi, 2011; Braun & Clarke, 2006)). For data analyses reasons, the data collected was transcribed verbatim, and thereafter the transcribed data was analysed and coded for frequent themes and patterns. The identification of themes in the current study progressed inductively or in

a bottom-way up as described in Braun and Clarke (2006). This implies that, the themes; patterns; and concepts progressed from the data collected, rather than be discerned initially by the researcher. In addition, the way towards coding the information did not include fitting the information to prior coding outlines or to the researchers' scientific presuppositions. Nonetheless, it is with of incredible significance to take note that researchers are not exclusively free of their hypothetical and epistemological responsibilities. The researcher followed the six essential steps of analysing data as described by Braun and Clarke (2006); the steps of thematic analysis are further discussed in the following section. The steps of thematic analysing qualitative data entailed the researcher to get familiar with the data collected; generating codes; searching for themes; reviewing the themes; defining and naming themes; and lastly reproducing a report of the findings (Braun & Clarke, 2006; Matabane, 2015).

4.6.1 PROCEDURE (STEPS) OF THEMATIC ANALYSIS

Braun and Clarke (2006) define thematic analysis as a qualitative data analysis technique for categorising, evaluating and reporting themes with data. Furthermore, Rubin and Rubin (1995, cited by Braun and Clark, 2006) are of the view that thematic analysis is stimulating because you find subjects and ideas implanted all through your interviews. Additionally, analysing the data includes a consistent moving back and forward between the whole informational index, the coded data, and the examination of the data-set. Moreover, thematic analysis is anything but a direct procedure of essentially moving from starting with one stage then onto the next. Rather, it is increasingly a recursive process, where development is forward and backward as required, all through the stages (Bomoyi, 2011; Braun & Clarke, 2006). The below section provides a concise description of the phases involved in thematic analysis and how the researcher used these to analyse data for the current research project.

A. Familiarising yourself with data

According to Braun and Clarke (2006) it is imperative for a researcher to be acquainted with all parts of information set. Additionally, the authors argue that whether the researcher has collected data by themselves, which particularly enables the researcher to have earlier information of the data before conducting the research and data analysis, and to perhaps have some underlying logical judgements and or opinions. It is anyway crucial to saturate themselves in the data-set to the degree that they know about the perceptiveness and broadness of the content of the data collected. Besides,

this is a tedious stage as it includes perusing and re-perusing and translating the information gathered. In spite of that, this stage is vital as it gives a foundation to whatever is left of the analysis. In this phase the researcher assumed an active role which included repeatedly "reading" the dataset; searching for meanings and patterns. The researcher read through the entire data set before beginning the process of generating initial codes. As the researcher of the current study was working with verbal data from the interviews, she began by transcribing the interviews verbatim into written form to provide orthographic transcripts and conduct thematic analysis. Further, the researcher kept in mind that, the transcripts should retain the information from the verbal account, and in a way, which is true to its original nature. Braun and Clarke (2006) suggest that this phase is time-consuming; however it is of great importance. As much as the process was time consuming, nevertheless, it was of importance value as this process enabled the researcher to develop a far more thorough understanding of the data set.

B. Generating initial codes

The decision among inductive and theoretical maps depends on how and why you are coding the information, and to some degree, coding relies upon whether the topics are more "data-driven" or "theory-driven" (Braun & Clarke, 2006). In addition, codes recognise a component of the data-set that seems intriguing to the researcher, and alludes to the most fundamental fragment, or component, of the crude data that can be evaluated ultimately with respect to the phenomenon. This stage includes arranging your data-set into significant clusters (Bomoyi, 2011; Braun & Clarke, 2006). In the current research, the coding procedure was done inductively, that is, the way toward coding was "data-driven". In this exploration, the coding was done physically by composing notes on the writings that was dissected and featuring the notes to show the potential patterns.

C. Searching for themes

This stage started when the whole data collection was coded and examined. As asserted by Braun and Clarke (2006) a theme catches something imperative about the data-set in connection to the research questions and speaks to some dimension of intended replies or subjective meaning in the data**.** The progression of this stage included seeking over the data and arranging of various codes into potential subjects and examining all important coded information-set inside the recognised themes (Braun & Clarke, 2006).In the current research this phase of data analysis entailed the researcher to look among all the interviews conducted to discover recurrent themes. Additionally,

the analyst made utilisation of a visual portrayal (table) which enabled her to deal with the diverse codes into relevant themes. The analyst read and re-read the information for any subjects that were identified to be relevant to the phenomenon that was researched and coded differently, without focusing on the themes that past research with comparable enquiry may have distinguished. As a result, this came about to five main themes being distinguished by the researcher, and these were (a) understanding and conceptualisation of mental illnesses and psychological wellbeing; (b) beliefs about the causes of mental illnesses; (c) African traditional interventions for psychological distress; (d) perception about the role of traditional healers in treatment of mental illnesses; and (e) issues related to help seeking.

D. Reviewing of themes

Reviewing of themes begins when the researcher has devised a set of candidate themes. This phase of thematic analysis involves the refinement of the candidate themes. The researcher looks at whether the potential themes precisely completely replicate the knowledge in the research data and furthermore consider the legitimacy of individual themes in connection to the data (Braun & Clarke, 2006).

E. Redefining and naming themes

This stage starts when the researcher has a considerable thematic guide of their dataset. Subsequently, the researcher then characterizes and further refines the subjects that they will show for their data analysis (Braun & Clarke, 2006). In the current study, the way towards characterising and refining started when the analyst recognised the substance of what each theme is about and figured out what parts of the data each theme encapsulates. The analyst further composed and led a point by point examination and recognised the narration each theme informs and how it fits to the entire research. In the concluding phase of refining and defining of themes these were the main themes that were recognised by the analyst (a) understanding and conceptualisation of mental illnesses and psychological wellbeing; (b) beliefs about the causes of mental illnesses; (c) African traditional interventions for psychological distress; (d) perception about the role of traditional healers in treatment of mental illnesses; and (e) issues related to help seeking**.**

F. Reporting the data

The data report ought to give a brief, intelligent, consistent, non-tedious and fascinating record of the subjective meaning of the data collected within and crosswise over themes (Braun & Clarke, 2006). In this research study, this stage started when there was an unmistakable and brief arrangement of formulated or developed themes. Moreover, this stage included the concluding analysis and review of the data report, which mandated the researcher to recount the perplexed meaning of the data collected, in a way that persuades the reader of the validity and quality of the data analysis and report.

4.7 ETHICAL CONSIDERATION

When research is conducted, there are many ethical issues that a researcher must take into consideration, to ensure that the participants and the researcher are protected, and that the study is ethically conducted. Amongst the utmost talked about ethical philosophies, the value of regard for research participants framed the fundamental basis on which the ethical considerations of the current study were based. Kometsi (2016) states that ethics committee normally direct the adherence to morally inclusive research standards. Furthermore, the international guidelines for research entail that all studies concerning humans must be submitted for review of their scientific legitimacy and ethical appropriateness to an independent ethics committee (Bomoyi, 2011). Additionally, the research studies that are university-based and that involve humans should be permitted and appropriated by a review committee beforehand. Nonetheless, in as much as, ethical review panels examine research proposals, the researchers are primarily in charge of protecting research participants (Kometsi, 2016).

Ethics are profoundly noteworthy in research; these considerations are to do with what is ethically right to request individuals to do, and how to treat the individuals who are requested to partake in a research study (Kometsi, 2016). Furthermore, in exploratory research, ethical issues especially emerge in view of the complexities of inquiring about private lives. When a researcher conducts research and converse with participants; dissect what they do and say, and report perceptions and findings to the public, this is a procedure with inevitable ethical challenges (Brinkmann & Kvale, 2005; Stainton Rogers &Willig, 2008). In addition, Kometsi (2016) asserts that maintaining moral standards and procedures endorses regard for the nobility of the research members and equalises

the risks in contrast to the advantages of the research. The ethical considerations of this study were impacted by the essential methods of basic research codes significant to research studies involving humans. The following section discusses how the research study addressed the important ethical problems that might have arisen when conducting the research study, these include but are not limited to confidentiality and anonymity; informed consent; non-maleficence and beneficence; and validity and reliability.

4.7.1 GATEKEEPERS' PERMISSION AND ETHICAL CLEARANCE

When research is conducted, there are many ethical issues to take into consideration to ensure that the participants and the researcher are protected. Moreover, the process of conducting a research project comes with inescapable ethical aspects (Brinkmann & Kvale, 2005). Nonetheless, there are various ways to ensure that ethical guidelines are followed, for this research gatekeeper permission was sought from the Keiskammahoek Amathole district councillor, see *Appendix 4(a)*. The University of Kwa-Zulu Natal necessitates that, each research considered by its employees and students should be exposed and acquainted to ethics review (Kometsi, 2016). In addition, ethics review committees are intended to give outsider evaluation to limit incompatible situations, ensuring the welfare of research members through the consideration of dangers, benefits and informed consent, and maintaining a strategic distance from abuse of incapable people and populaces. The fundamental focal point of ethics review committees is to safeguard participants of a research study and to guarantee that they had given informed consent.

In the current study, ethical clearance was sought and granted by the University of Kwa-Zulu Natal's Humanities Social Sciences Research Ethics Committee before the researcher could continue with collecting data. The ethical clearance number of the current study as obtained from the ethics committee is HSS/2022/018M, the ethical clearance document is attached *appendix 5(a).* As indicated by Kometsi (2016) gatekeepers are generally members who have personal stakes either in the current issue being researched or in the prosperity of the potential research member**.** In the current study, a meeting was held with the gatekeeper of Keiskammahoek community, to gain entry to the participants of the research and the exploration or research area. In the meeting that was held with the gatekeeper the background of the exploration, aims and objectives, and the data accumulation technique was concisely outlined and clarified, so that the gatekeeper gets the full understanding of the study before giving permission to the researcher to conduct the study.

Subsequently, a letter that was approved by the supervisor of the project that was requesting gatekeeper permission was forwarded to the relevant person, *See appendix 4(a).*

4.7.2 INFORMED CONSENT

According to Neuman (2011, p.151) informed consent refers to "a statement, usually written, that explains aspects of a study to participants and asks for voluntary agreement to participate before the study begins". Accordingly, Kometsi (2016) contends that gaining informed consent is essential for research members to partake in any research. A consent is generally acquired with the utilisation of an informed consent form, which is ought to be signed by the research participants before partaking in research (Bomoyi, 2011). Nonetheless, the way towards acquiring the member's informed consent is significantly more multifaceted than the negligible signing of a consent form, yet rather is a consent to take part in a research study (Kometsi, 2016). In line with this insight, the researcher rigorously communicated all aspects of the study to participants, when they were first approached. The participants were asked to sign the informed consent form directly prior the interviews. This form related to issues of confidentiality, non-maleficence, and beneficence. Furthermore, Durrheim and Wassennar (1999) suggests that informed consent is ought to be a procedure that includes passing on precise and pertinent data about a research study; its motivation, potential advantages, and known dangers in a dialect which the participant best comprehends. Also, the data involved in informed consent form must be valid and should cover all the significant perspectives of the study. In support of Durrheim and Wassennar (1999) suggestion, the researcher provided the research participants with informed consent forms that were in English language, *see appendix 1(a)* and IsiXhosa language, *see appendix 1(b*).

As indicated by Kometsi (2016) in research, informed consent of individuals before including them in research is considered as the standard and required method for regarding their autonomy**.** This ought to exhibit that the autonomous member has not been controlled or constrained at all into consenting. Likewise, for an autonomous choice to participate in research to be made, that research members must be given adequate and valid data with respect to the research before they sign an informed consent form (Bomoyi, 2011; Kometsi, 2016)**.** In line with this understanding, the current research adhered to the principle of voluntary consent, where the participants only participated in research explicitly and freely. In the present study no research members were constrained to partake in the study. The researcher was extremely aware of the way that the rule of informed

consent is firmly identified with the guideline of autonomy and capability to consent. Kometsi (2016) claims that to improve autonomy, before signing a consent form, members of the research must be made mindful that they can pull back from the study whenever there be a need, without giving any reasons (Boeije, 2010). This unlimited and ultimate right of withdrawal from partaking in the present study was made unequivocally obvious to every single research member**.** In correspondence with the guidelines of informed consent, it was conveyed to the members of the research that, the privilege to end interviews whenever they feel the need to do so (Boeije, 2010; Kometsi, 2016) Subsequently, the essential standard conserved in the present research, as expressed by Slowther et al. (2006) is that a research study cannot be done where it includes person who is incapable to give consent, and this is particularly so in the current study, no participants that lacked the capacity to give consent were interviewed or participated.

4.7.3 CONFIDENTIALITY AND ANONYMITY

Confidentiality is an ethical principle in research, which is employed to protect the participants who are being studied by means of holding research data confidentially and storing the data secretly from the public, not releasing data in ways that will associate participants to specific responses (Neuman, 2013). The privacy and obscurity of research members was kept-up throughout this research. The rule of confidentiality is interpreted as meaning, not revealing to other people recognisable data accumulated amid the procedure of investigation about research participants. Meanwhile, to guarantee research members' confidentiality implies that what has been examined will not be repeated, or if nothing else not without the member's consent (Kometsi, 2016). On the other hand, namelessness is characterised by Ong and Weiss (2000) as a condition in which the identity of the members of research is not identified. This is much the same as the rule of privacy in research. Additionally, infringement of confidentiality can happen while distinguishing data about the research member is dispersed to people for whom it was not intended, without the research member's consent (Kometsi, 2016).

The researcher ensured that the data collected from participants was kept confidential; this was achieved by storing the audiotapes of the interview safely, so that no one besides the researcher and supervisor of the project has access to the information supplied. The researcher ensured that participants' names were not related with any information that they gave, whether written or oral presentation and or discussion of this research. Kometsi (2016) brings forth a mindfulness that

infringement of privacy may happen purposely, as well as coincidentally. Nonetheless, the most ideal method for ensuring the confidentiality of research members, even from the likelihood of coincidentally breaking confidentiality, is through the procedure of anonymisation. Moreover, the normally utilised technique for anonymising research members is using pseudonyms. In line with this perception, the current study used pseudonyms to discuss the findings of the study. Additionally, the researcher ensured that anonymity of participants was reserved, by not disclosing any participants' identity after information was collected. This is an ethical principle that protects the identity and disclosure of participants by remaining nameless or using pseudo-names to refer to them and report findings (Neuman, 2013).

4.7.4 NON-MALEFICENCE AND BENEFICENCE

The researcher is constrained to reveal to the members of the study the dangers related with being a participant in a research study (Bomoyi, 2011)**.** Additionally, research that involves human beings is ought to never harm the participants, irrespective of whether they have volunteered (Riet& Durkheim, 2006). Further, the researcher is accordingly committed to meticulously measure potential risks of partaking in a study and work diligently to limit or dispense the identified risks (Kometsi, 2016). The researcher had undertaken the necessary steps to ensure that the participants were not harmed, be it psychologically; emotionally; and or physically. In addition, the researcher ensured that the participation in this research study was voluntarily and that the participants had the autonomy to leave at any period of data collection when they wished to do so (Boeije, 2010). In as much as, there were no potential risks for psychological; physical; and or emotional harm in this study identified by the researcher, and it was brought to the participants attention that, when the participant(s) experienced distress during the progression of the interviews, the researcher/ interviewer should be informed, and the researcher will take the necessary steps, by liaising with the supervisor of the project to provide necessary recommendations should there be any experience of psychological distress.

Ethical treatment of research members suggests regard for their choices as well as advancement of their well-being. Moreover, every research study ought to dependably be propelled by considerate respect of participants and stringent commitments of non-maleficence. Furthermore, Quest and Marco (2003) contend that to direct morally thorough research, the researcher must find a way to guarantee that members of the study, including their families and the location of the research, will

not endure undue social and psychological damage for the sake of research. It was brought to the participants' attention that, there are no immediate and direct benefits to the participants and Keiskammahoek community. Nonetheless, the findings from the study contribute to the body of knowledge related to mental health. Also, the results from the research study contribute positively to the understanding of indigenous worldview of mental illness, which will be helpful for mental health professionals to be open to cultural knowledge, with the directive to reduce misinterpretation and misdiagnoses of indigenous clients.

Kometsi (2016) is of the view that, each research should directly profit the members of who partaken in a study, or the more general populace, and the advantages of the exploration ought to fundamentally exceed the potential damage to research members. In addition, Emanuel et al. (2000) express that a research study ought to create more noteworthy developments in wellbeing and prosperity. In the current study research participants were informed that there are no immediate, prompt, individual advantages for participating in this research. Nonetheless, they were informed that their participation in research study will benefit the community of Keiskammahoek in that, the findings help to explain individual's subjective experience and explanation of mental illness and psychological wellbeing, and the treatments thus used for mental illnesses. The research participants were additionally informed that the data acquired from them could be utilised by healthcare developers for the arrangement of emotional wellness administrations, government authorities and or community-based associations occupied with healthcare training, including mental healthcare and community healthcare promotion. Concurrently, the research findings will yield vital information that can be utilised by the mental health care system within and thereof outside the community of Keiskammahoek, and these might contribute to clients being met with mental health care that acknowledges them in their own context and take cognisance of the cultural differences that characterise a multicultural country like South Africa.

4.7.5 SELF-REFLEXIVITY

Self-reflexivity refers to the concept and process of analytical analyses of the researchers' role in conducting qualitative research (Palaganas, Sanchez, Molintas, &Caricativo, 2017).In addition to that, it is worth noting that qualitative research design is in nature subjective, nonetheless it is as important that the researcher be aware and conscious of their values, interests, and beliefs when

conducting research. Additionally, it is equally significant that the researcher spends adequate time reflecting how their values, interests, attitude, background, and beliefs affect the research process. And how these may or may not cloud the research process, and therefore the research findings. Moreover, Palaganas et al., (2017) argues that self-reflexivity as a process, involves self-awareness and playing an active position in conducting the research project. In this current research the researcher dealt with her biases and presumptions concerning the phenomenon that would have affected the entire research process and findings, this entailed taking a considerable time reflecting on her background; values and beliefs, and the preconceived assumptions about the phenomenon at hand. In as much as it is difficult to entirely discard one's values and beliefs, it is as important to be objective meanwhile conducting a study. For instance, the researcher used the necessary scientific tools and objectivity while conducting interviews and in the whole research project. The researcher noted that some participants could not understand some research questions which were articulated in English language; this entailed the interviewer to interpret those questions during the interview process. The process of interpreting these questions to IsiXhosa was not difficult to do, since isiXhosa language is a native language to the researcher. Additionally, self-awareness and consciousness helped the researcher to be objective in this process, and not allowing preconceived ideas, values and beliefs, and interests to cloud and affect the process of data collection.

4.8 CONCLUSION

In conclusion, this section of the research discussed the research approach including the research design, the research members of the study, data collection procedure and technique. Additionally, the challenges that the researcher experienced meanwhile conducting the study were precisely discussed. Moreover, the sampling method and description of participants was delineated. Data analysis procedure and the steps involved in analysing qualitative data for this current research was completely outlined, including the research paradigm/ epistemology was discussed. The last section of the study discussed the ethical issues experienced and considered in the current research. The research findings are displayed, discussed, and outlined in the following chapter.

CHAPTER FIVE: DATA ANALYSIS AND RESULTS

5.1 INTRODUCTION

South Africa is described by a variety of societies and cultures, and the people of South Africa embrace different sociocultural practices which characterise who they are as Africans and cultural groups (Kometsi, 2016). This current chapter presents the findings of this study. Firstly, the demographics of the sample of this study are outlined and vigorously delineated. The following section to that, is the presentation of results, these are presented in two sections. The first section presents the results from group one participants (general population), and the second part presents the results from group two participants (traditional healers). Subsequently, the discussion of the results from this study is presented, and tables are used to enlighten the discussion and summarise the key points of the research finding. The chapter is then ended with a conclusion and the significant and main results are encapsulated. The analysis of the findings for this current study led to an identification of five main thematic areas, namely (a) understanding and conceptualisation of mental illnesses and psychological wellbeing; (b) beliefs about the causes of mental illnesses; (c) African traditional interventions for psychological distress; (d) perception about the role of traditional healers in treatment of mental illnesses; and (e) issues related to help seeking. The discussion of the main themes and subthemes is in the subsequent sections and the provision of some of the extracts as quoted verbatim from the participants responses are written in italics.

5.2 DEMOGRAPHICS OF THE SAMPLE

The total number of participants that were interviewed for this research was eight and the participants were recruited respectively from Keiskammahoek surrounding areas. The eight participants that were part of the sample, three males were interviewed, and five females were interviewed. Since the participants were grouped into two groups, the first group of participants which were interviewed five participants participated as part of the sample for this group. The second group of participants were traditional healers and only three participants were part of the sample for this group, one male traditional healer and two female traditional healers were interviewed. All the participants were between the ages of 35 years and 60 years, and the participants were respectively Xhosa by birth. Furthermore, in terms of education level and literacy the sample included participants that were professionals and non-professionals, five out of eight participants have tertiary level education, and the remaining three have secondary level of education.

5.3 RESULTS OF GROUP ONE PARTICIPANTS

5.3.1 UNDERSTANDING AND CONCEPTUALISATION

There are different conceptualisations and understanding of mental illness and psychological wellbeing, all of these are related to the different worldviews that people ascribe to, and to the ontology; philosophy, and paradigm that various people hold. Kometsi (2016) argues that African conceptualisation of illness is for the most part ascribed to causes beyond the borders of the persons' illness and is either not or infrequently viewed as a physical issue or breaking down of the body. In any case, this does not infer that African perspective denies psychosocial aspect as amongst the causal explanations of illness. This part of the research study outlines the results concerning the understanding and conceptualisation of mental illness and psychological wellbeing. To assess how mental illness and psychological wellbeing is conceptualised and understood, the participants were asked about their understanding of the two phenomena. Furthermore, some of the participants were probed and asked to explain certain concepts and descriptions.

5.3.1.1 MENTAL DISTRESS

Many participants understood and conceptualised mental illnesses in relation to behavioural and developmental terms. In addition to that, there were participants who conceptualised mental illness in terms of psychological and thinking processes, were a mentally ill person would be described as imposing danger to themselves and others, loitering around the streets etc. In this case, one of the participants Pearl conceptualised mental illness as:

"when a person, whether female or male, child or adult, is not in contact with the real situations of life mentally, in other words does not understand and acting or doing things the normal way" (Interview 2, January 2019).

Furthermore, the conception of psychological maladjustments was frequently related and associated to social and cultural norms were most participants believed and conceptualised a person who has psychological challenges as acting outside of social and cultural norms. For instance, Khumalo argued that:

"my understanding is…. when a person behaves in a way that is…funny, that is not acceptable especially for his/her age group. Also, when he seems not to be developing mentally as

he should be. There are norms in any type of society, that is what one is expected to do and what one should feel ashamed of doing in public" (Interview 1, January 2019).

5.3.1.2 PSYCHOLOGICAL WELL-BEING

Most participants understood and conceptualised psychological wellbeing as a state of mind and behaviour that is associated with thinking process, acting, and behaving in accordance with the sociocultural norms and values. In this argument, Khumalo was quoted:

"Ummh, yes! Psychological wellbeing, I think it means the proper functioning of the brain. Ummh, when the brain commands the person to behave in a way that is proper and also acceptable" (Interview 1, January 2019).

On the same sentiment, Khwezi commented:

"Ummh…to me…thinking…it's only when a person is doing the right thing and at the right time. Normal things, good things at the right time" (Interview 4, January 2019).

In addition to that, psychological wellbeing was conceptualised as developing in relation to your age group and doing things that are related to that age group. For example, Zama responded:

"it means that I must be somebody who is a grown up…thinking…who is grown up and thinking normally and who can do things that can be done by adults as I am an adult. Additionally, it can also apply to children because at some certain stage you are supposed to do this, and some stage you are supposed to do that" (Interview 3, January 2019).

On the other hand, one of the participants related psychological wellbeing to not only the mind but involving a holistic analysis of the person as a whole being that is the mind working in congruence with other elements of the person, including the spiritual and physical aspects. Pearl commented saying:

"psychological wellbeing, I think is when a person is in contact with real life and their mind is working congruently. Including his/ her physique; and also, his/ her soul but it emphasises on the mind I think" (Interview 2, January 2019).

5.3.2 THE BELIEFS ABOUT THE AETIOLOGY OF PSYCHOLOGICAL DISTRESS

The aetiology of illnesses is likewise viewed as supernatural, represented by a chain of essential forces starting with a most dominant god pursued by lesser profound elements, genealogical spirits, the living people, creatures, plants, and the disharmony between these imperative forces can cause disease (De Andrade, 2014; Kometsi, 2016; Melato, 2000; Sandlana & Mtetwa, 2008; Thabede, 2008). There are additionally ideas of black magic and divination; both accepted to be equipped for realising sickness and demise that are firmly identified with the idea of predecessors and God (Bereda, 2008; Melato, 2000). The following part of the results presents the participants' etiological beliefs about the causes of mental illness. To assess the beliefs about the causes of mental illness, the participants were asked their beliefs about the causes of abnormality, their responses were mostly traditional beliefs such as: witchcraft' angry ancestors; ancestral calling; a need of traditional rituals and evil spirit. Nonetheless, there were participants who believed that psychological distress might be a result of environmental and social factors such as poverty; drug and alcohol abuse; accidents and trauma; and childbirth. These responses were then grouped into four categories namely animistic; magical; mystical aetiology; and psychosocial causes. Subsequently the last part of this section presents the results concerning the link between the beliefs about the aetiology and conception of mental illness.

5.3.2.1 BELIEFS ABOUT THE CAUSES OF MENTAL ILLNESS

A. ANIMISTIC AETIOLOGY

The majority of participants expressed that the beliefs about the causes of mental illnesses depend on the cultural beliefs of that person, with that being said the vast number of participants were of the belief that psychological maladjustments can be caused by angry ancestors and a broken relationship with your ancestors. In relation to that, traditional healing was considered to be the only intervention that can be used to treat mental illnesses, were by the traditional healer would appease to the ancestors on behalf of the person. In addition to that, traditional rituals were also believed by a considerable number of participants to be one of the aetiology of mental maladjustment. The participants believed that if certain traditional rituals were not done for a person, that could consequence to a person having mental illnesses, additionally, if certain cultural rituals were not done appropriately that could as well cause psychological challenges. For example, Khumalo responded:

"*ummh mental illnesses ummh (thinking)…my perception would be that, maybe, some traditional rituals where not done properly to the person…when a child is born there are some traditional rituals that need to be done for them. Like, ummh… if I may call it, imbeleko is one of these. We do have that belief that if things like those are not done. It will show in that person's life, later on. For instance, the grown up will show that something was not done"* (Interview 1, January 2019).

On the other hand, most participants believed that refusing ancestral calling *ukuthwasa* in isiXhosa, can cause psychological disturbances and the only way to compensate and treat that is through the execution of the traditional ritual of *ukuthwasa*. For instance, Khwezi in his response articulated that:

"causes of mental illness depends on…thinking… ummh, it depends! One could be the belief, of the challenge in the traditional needs of that person. Number two ummh, it could be witchcraft, number three could be social challenge like trauma. Ummh, those are the three that I have in mind" (Interview 4, January 2019).

B. MAGICAL AETIOLOGY

More than a few participants believed that mental illnesses can also be caused by witchcraft or bewitchment, many participants suggested that there is a belief amongst AmaXhosa that wizards and witches referred to as *amagqwirha or abathakathi* in IsiXhosa language correspondingly, can be the root cause of psychological maladjustment, by using their destructive and evil spirits. For instance, Zama responded and said:

"sometimes it is due to witchcraft. For instance, when I was growing up my neighbour, used to say to my parents: Your child won't go anywhere. Since then, I didn't grow up as an adult to do things that are normal" (Interview 3, January 2019).

Similarly, Khwezi was of the view that psychological abnormality depends on the cause and is not entirely caused by witchcraft. He stated that witchcraft can be amongst the other aetiological factors and was quoted:

"The causes of mental illness depend; it could be witchcraft. Let me make an example, the cause at that time was witchcraft. And we had to take this man to the traditional healer, and the

traditional healer did treat him and gave him some herbs, after that he became okay" (Interview 4, January 2019).

C. PSYCHOSOCIAL CAUSES

It is worth noting that most participants did not mention psychosocial factors to the aetiology of mental illness. Regardless of that fact, a limited number of participants did however believe that psychological abnormality is not only caused by traditional related factors but contextual; environmental and causes do take part in the aetiology of mental illnesses. For example, Pearl said in her argument that:

"when I'm thinking there are various causes for mental illnesses). I think the cause of mental illnesses revolve around the family. It may be that, in the family there is a history of mental illness. Also, mental illnesses may be due to social life situation, especially those that are aggravated by poverty; excessive use of drugs and liquor; violence in the area or the community. Also, mental illness can be…it can occur to people especially to women after they have delivered" (Interview 2, January 2019). In a similar sentiment, Thando responded and said:

"I think mental illness may be caused by abusing liquor; by abusing drugs; sometimes it may be caused by a situation of a parent. Let's say this child, when the parent was pregnant, she did not have money, was poor or sometimes was a disturbance on the marriage, let's say she was abused by the partner" (Interview 5, April 2019).

5.3.1.2 THE LINK BETWEEN THE BELIEFS ABOUT THE AETIOLOGY AND CONCEPTION OF MENTAL ILLNESSES

According to the responses of the participants, there was a strong link between their aetiological beliefs and their conceptualisation and understanding of psychological abnormality. For example, most participants believed that mental illnesses can be caused by bewitchment; refusing ancestral calling; evil deed of the person etc. all of these are associated with indigenous worldview. Nonetheless, there were participants whose view about the causes of psychological maladjustment were related to Western worldview, in their responses they mentioned social factors such as accidents; poverty; unemployment; drug and alcohol abuse etc. In addition to that other aspects such as trauma; dysfunctional families; childbirth and or pregnancy and more were expressed as one of the causal factors of mental illness. For instance, in one of the interviews conducted in

January 2019, in Khumalo's response it can be assumed that there was a strong link on how he perceives and conceptualises mental illness and his beliefs about the causes of mental illness. In addition to that, he mentioned that he would recommend western treatment in any illness that has to do with psychological wellbeing. The participant showed much of a Western understanding and orientation to the understanding of mental illness. However, there was traditional view to the phenomenon. It can therefore be assumed based on the results of this current research, the participants' view and conceptualisation of mental illness is linked to their etiological beliefs.

5.3.4 THE AFRICAN THERAPEUTIC METHODS

The African therapeutic method is a holistic framework of healing that gives efficient treatment and that considers the patients' psychological, physical, and spiritual entities and as well as their setting, this infers that it is a complete procedure of recuperating which includes the living and the dead, the natural and the supernatural, in connection to the issue exhibited by the patient (Kometsi, 2016; Sandlana & Mtetwa, 2008). Additionally, the individual is treated inside the setting of their family; network; and religion (Melato, 2000). This subsection discusses the results of the current study which are related to the African therapeutic methods or interventions which traditional healers and Xhosa people respectively use to treat health related problems including mental illnesses. The participants were asked questions like; what therapeutic methods are used by the Xhosa people in treatment of mental illnesses, to get a full understanding of some of the treatment methods that are frequently and normally employed in the treatment of mental illnesses. The responses from participants were then grouped into three sub themes namely: African traditional medicine; African traditional divination; and African traditional rituals, these sub themes are discussed in the following sections.

5.3.4.1 AFRICAN TRADITIONAL MEDICINE

The majority of participants were of the sentiment that, there are various ways that traditional healing is used as an intervention to mental illnesses and or any other illness. The participants in their responses regularly mentioned African traditional medicine and mixtures that are used by indigenous healers in the treatment process. Pearl responded:

"They use herbs, that is their first method, but there are other methods like: isiwasho (where they cleanse the person); ukuqaphula (cutting and protecting the person from evil or incision);

ukugabha (induced vomiting), and ukucima (cleansing). And also, the other methods such as giving you medicine to take orally" (Interview 2, January 2019).

In addition to that, many participants expressed that these therapeutic remedies and mixtures are communicated to traditional healers by the ancestors through dreams *(amaphupha)* and imagination *(ukuboniswa)*. For example, Khwezi argued that:

"they've got their own kinds or methods in dealing with that, once again I said they use herbs, there are herbs that were identified by the ancestors…… We would invite a traditional healer for intervention, there are different herbs that were identified for this particular problem" (Interview 4, January 2019).

5.3.4.2 AFRICAN TRADITIONAL DIVINATION

Many participants stated that traditional healers use divination as one of their methods to help and treat their clients. In most of their responses, the participants argued that African traditional divination is a process where the indigenous healer would normally consult the ancestors on behalf of the person and or family for guidance and direction during the treatment process. Additionally, the traditional healer can appease to the ancestors. This method of divination is believed to be helpful to many African people in relation to gaining insight into what is the cause of the ailment and why is the person sick. In this case, Khwezi was quoted:

"It's very important, especially to us as Africans. Once again, depending on the belief, because traditional healers do heal people, I have a 100 percent guarantee about that. They've got their own kinds or methods in dealing with that, once again I said they use herbs, there are herbs that were identified by the ancestors. Number two elders and even the traditional healers will invite the ancestors to intervene in those particular things ... as an African person you don't undergo any method without the intervention of the Izinyanya, that is the ancestors. For one: direction, they give you direction; guidance and support in this particular thing" (Interview 4, January 2019).

5.3.4.3 AFRICAN TRADITIONAL RITUALS

A significant number of participants believed that, if a person does not do certain traditional rituals and or does not do them appropriately that might cause psychological maladjustment. In such a

case, the execution of the needed rituals must be performed with the help of a traditional healer. Khwezi expressed that:

"depends on the cause because for some the cause is that there is a need for some ritual or traditional functions of that particular person, then the traditional healers would do the traditional functions to heal that particular person, and once again the elders in the family have got their own approach using our African indigenous approach, not even using the herbs" (Interview 4, January 2019).

Furthermore, the participants in their responses also mentioned different rituals that might be a contributory factor to ailment, some of these include *imbeleko* (child introductory ceremony); *ukwaluka* (circumcision ceremony); *ukungxengxeza* (appeasing to the ancestors) etc. For example, Pearl articulated:

"Ummh… I think traditional healers have a role, especially when you are told that you are sick because you didn't do this and that. Like you have not done imbeleko (a Xhosa ritual that is done to introduce the child to the ancestors), you have to slaughter a goat; your ancestors are angry because you didn't do a certain ritual" (Interview 3, January 2019).

5.3.5 PERCEPTION ABOUT THE ROLE OF TRADITIONAL HEALERS IN TREATMENT OF MENTAL ILLNESSES

The indigenous therapeutic professionals are found in many social orders and they are frequently part of a neighbourhood network, culture, and conventions, and keep on having high social standing in numerous places, applying effect on local health practices (Sandlana&Mtetwa, 2008; Sodi, 2009). According to Kahn and Kelly (2001) there are different kinds of indigenous healers known to Xhosa speakers. In any case, the nonexclusive term indigenous healer is regularly used to allude to every one of them. In this research study, the term traditional healer and indigenous healers are used interchangeably and are used to refer to the generic categories of traditional healers. The following section outlines the results about the participants' perception about the role of indigenous healers in the treatment of mental illnesses. In the quest of their perception, the participants were asked the role they have on treating mental illnesses.

5.3.5.1 TRADITIONAL HEALERS' ROLE.

The results from this study suggest that, indigenous African healers are a significant part of the cultural and community. Furthermore, the results from the current study suggest that there are

several roles played by the indigenous healers, many of the participants believe that traditional healers play a role of advising and diagnosing of illnesses. For example, Khumalo stated that:

"In mental health, ummh, to me traditional healers and ancestors work together. Because we have a belief (and I have a belief that) the traditional healers do form a link between the living and the ancestors. They do form that link, in the way of monitoring how traditional rites are done in the way of advising, diagnosis. Yes, what to be done and how this must be done" (Interview 1, January 2019).

Additionally, traditional healers are believed to aid with executing of treatment and traditional rituals which is not measured in a Western way and issuing of African traditional medicines, some traditional healers use prayer, specifically the faith healer Pearl responded and said:

"If I hear you properly their role in treating mental illness is to make patients to believe that they are going to be healed. They also, give medication, however their medication is the medication that is not measured in ... paused…the western way. Their role is to also offer prayer especially when you go to the faith healers" (Interview 2, January 2019).

Moreover, many participants believed that indigenous healers provide the person who is ill and the family with mainly the causes of mental illness. In addition to that, some participants believe that indigenous healers help with advising and directing the family of the person and the person who is ill on what to do, how to do it and when to do what is needed to be done. For example, Khwezi argued:

"*Even when you dream, you communicate with your father (ancestors) and say this is the problem, they will give you direction and say that for this medicine go to this particular place or tree. So, we have this belief that they have a crucial role to play"* (Interview 4, January 2019).

Many participants also believe that indigenous healers work with the ancestors, and act as the mediators between the ancestors and the people. For instance, if the aetiology of illness is believed to be angry ancestors, indigenous healers help with appeasing to the ancestors, and the ancestors

will give direction and guidance to the healers on what needs to be done. In this case, Zama responded:

"*…traditional healers, ummh since I am the person that was not helped by them, traditional healing. I think they help with ukuvumisa (prophesy) that you are sick because of this and that"* (Interview 3, January 2019).Furthermore, Pearl stated that:

"If you go, for instance, some of the traditional healers can go to the kraal, where they will communicate to the ancestors in the kraal to tell them about their problems or they can even, they can go by the graves of their ancestors to seek for help" (Interview 2, January 2019).

In contrast to the view of many participants, some participants believe that traditional healers have no role in the treatment of psychological abnormality. For instance, Khumalo argued and said:

"I do not subscribe to them when it comes to treating mental illnesses. Only if it is for the diagnosis, that's what I agree with. When they diagnose that this ritual was or is not done, I only subscribe to that extent. Yes!.....Ummh as I have just said, with me it only ends with diagnosing what was not done properly in the traditional rituals and advising how to go about that. I've seen some people after undergoing what has been advised, Yes, coming up now healthy but when it comes to (paused)…healing, ummh in the way of healing like thee medical people do, I do not see any role that they can play" (Interview 1, January 2019).

5.3.6 THE ISSUES RELATED TO HELP-SEEKING.

There are many issues related to help seeking for mental health problems, one of which is that in the greater parts of developing nations, emotional wellbeing activities have low priority irrespective of the worsening weight of psychological illnesses (Mkhize & Kometsi, 2008; WHO, 2001). Moreover, a considerable number of people with mental issue endure quietly and without consideration, as a result of insufficient mental health care institutions identified and other related issues which regularly contrarily affect help seeking for practices in people with dysfunctional behaviours. Notwithstanding that, most people cannot get to some type of treatment and the individuals who do get treatment are more than once uncovered to extreme and disparaging living conditions when they are in psychological institutions (Lund, 2007). This part of the results

discusses the barriers that the participants outlined and mentioned in their responses, as likely to have or experience when seeking for help for mental health care. The responses from the participants included difficulty to access mental institutions; language; culture i.e. different cultural backgrounds, beliefs and orientation; lack of knowledge and education, economic cost i.e. poverty, and unemployment.

5.3.6.1 ACCESS TO MENTAL HEALTH CARE

Many participants mentioned that, there is difficulty in accessing mental healthcare institutions especially for the people who are in rural settings and this was the case for them. For example, Thando expressed that:

*"Okay ummh... in my town or village, that is Keiskammahoek, there is a lack of mental institutions. So, there is no one, there are no mental institutions that can help those people who are mentally ill…..on the other hand, people who are mentally ill, do not get enough help just because of that lack of institutions, because of the lack of nurses or psychologists that can help them"***(**Interview 5, April 2019).

Likewise, Khwezi commented on the issue of the need of psychologists in rural areas. He responded and said:

"Ummh, now because of time this era needs more psychologist but unfortunately, we live in rural areas, places where there are no resources or limited resources. Yes, we have got traditional healers, but the value and quality of traditional healers that we have in our days is not the quality that we have had, that our forefathers have had before" (Interview 4, January 2019).

In addition to that, the participants stated that there are no mental institutions in Keiskammahoek region which results to, too many people not receiving the mental health care they need, and consequently the alternative use of treatment that is readily available to them. Zama was quoted:

"there are many problems we face because there are many people loitering around the streets, these people you do not know whether they do have families because they are dirty, eating in the bins and in the streets, not knowing where they are sleeping. If the traditional healers together with the Western they can have a center for those people. I think this can be solved" (Interview 3, January 2019).

Furthermore, the participants declared that many people who needed psychological healthcare are found in the streets because they do not have adequate healthcare services in their areas, if that is not the case other barriers hindered them to accessing mental healthcare. For instance, Khwezi responded:

"it is so common to find people with psychological challenges, because there is a high rate of crime; high rate of unemployment; there is imbalance in the society; element of cruelty; lack of honesty; gaps within the family; lack of honest people like elders in those days, even in the churches, societies……for instance, when you go to King, the nearest place. East London the nearest place, look at the distance. People are unemployed there is poverty now, there is no money things and taxis are expensive and they are unable to go to urban areas where they will find Psychologists, they end up becoming victims of these fake traditional healers" (Interview 4, January 2019).

5.3.6.2 OTHER BARRIERS RELATED TO MENTAL HEALTH CARE.

Many participants stated that there were barriers which hindered them to help-seeking for psychological problems besides not having to easy and necessary access to these institutions. In their responses most of the participants believed that language might be an issue when accessing mental healthcare. In this case, Zama was quoted:

"On the other hand, the other challenge I had with the psychologist was the language and it is a barrier. We use the Xhosa way of doing things, and they use the Western way, that was my other challenge" (Interview 3, January 2019).

In the same light, Thando argued as well that for African people language can be a barrier. She further added that, the other issue that she thinks might be a challenge when seeking psychological help would be the differences between the beliefs of the client and that if a professional. For instance, she argued that psychologists do not understand our beliefs as Africans. She was quoted saying:

"As an African language is a barrier, sometimes psychologists do not understand our beliefs. They believe that if someone is mentally ill, that person can use medicine; tablets; pills, and they do not believe in roots and also in plants" (Interview 5, April 2019).

Similarly, Khwezi had the same sentiments as that of other participants. He added to the issue of language and different belief systems, the issue that is related to the training of Western professionals. He argued that, the western training does not necessarily incorporate and accommodate indigenous approach, thus the challenge in that their value system and that of clients may significantly differ. Khwezi expressed that:

"the training and because of the exposure the Western one. The other challenge is because of the language, those could be the barriers. Number one: they won't understand the terminology as well, it will differ. Ummh the problem with training in the Western one is that, the traditional one or the indigenous approach is not accommodated in their training" (Interview 4, January 2019).

5.4 RESULTS OF GROUP TWO PARTICIPANTS

5.4.1 UNDERSTANDING AND CONCEPTUALISATION

There are different understandings and conceptualisations of mental illness and psychological well-being, all of these are related to different worldviews that people ascribe to, and the African culture is not standardized in nature. It is in this way anticipated that African sociocultural communities have various convictions about the aetiology and treatment of illnesses, and that there are contrasts in the manner by which ailments are conceptualised and managed (Kometsi, 2016). For example, in other sociocultural settings ailment is characterised in regards of social, physical, and profound connections, meanwhile in other parts of the society ailment is mostly conceptualised as a supernatural phenomenon. The following section of the research project presents how traditional healers define, understand and conceptualise mental illness and psychological wellbeing. To assess how mental illness and psychological wellbeing is conceptualised and understood by traditional healers, the participants were asked about their understanding of the two phenomena. Furthermore, some of the participants were probed and asked to explain certain concepts and descriptions.

5.4.1.1 MENTAL DISTRESS

Many participants in this group believed that psychological abnormality was related to tradition and sociocultural norms. Mental illness was understood and conceptualised in terms of refusal to do certain traditional rituals and norms. In addition to that, the sentiments of participants about

mental illness were significantly related to indigenous worldview. Moreover, mental illness was considered to be something that is not supposed to be happening and happens because people refuse to do what the ancestors require of them. One of the participants mentioned that, psychologically challenged people would do things that are abnormal, that are usually not done by a normal person, in relation to that mental illness was associated with sociocultural norms. Bongi expressed that:

"*ummh...thinking...I understand mental illness as an illness that is not supposed to be happening but happens because people do not want to accept their calling, to some people it is however caused by evil spirits…what I noticed about mental illness, the person who is mentally disturbed will do things that are unusual and that are not done by a normal person. For example, a person who is psychologically challenged will walk in the streets naked; eat in rubbish bins, sleep on the streets and beat other people without a reason……most of the time this happens when a person is not in good standing with their ancestors, sometimes when a person does not answer the calling of being a traditional healer, and because of that the person ends up being psychologically disturbed"* (Interview 6, January 2019).

The participants had a similar view and conceptualisation of mental illness. Furthermore, the participants had corresponding description of a psychologically challenged person which was mostly being dirty; sleeping and loitering around the streets; eating in rubbish bins, imposing danger to themselves and others etc. For instance, Gugu stated that:

"being psychologically challenged, I would explain and say that when a person wonders around the streets, eating from the rubbish bin; or when someone without any reasons beats other people up. When that happens, we take it as though the person is mentally ill" (Interview 7, January 2019).

5.4.1.2 PSYCHOLOGICAL WELL-BEING

Many participants conceptualised and understood psychological wellbeing as related to mental stability and doing good and purposeful things in life. For example, Gugu was quoted:

"a person who is psychologically stable does not do things that are abnormal and does things that are purposeful with their lives" (Interview 7, January 2019).

Furthermore, psychological wellbeing was related to being mindful and conscious about things that are happening around them, this therefore means that a person who is psychologically well would know what happens; what has happened and how that happened. In relation to that, Sizwe responded:

"A person who is psychological well knows for instance what they dreamt about, has a good memory and is aware of what is happening" (Interview 8, January 2019).

5.4.2 THE TRADITIONAL HEALERS' PERSPECTIVE ABOUT THE CAUSES OF MENTAL ILLNESSES.

The aetiology of illnesses is seen as a mystical phenomenon administered by different levels of leadership of powers emerging with the most predominant supernatural being sought after by lesser gods, innate spirits, living individuals, natural entities, and a break between these key powers can bring about illness (Kometsi, 2016; Sandlana & Mtetwa, 2008; Thabede, 2008).The following part of the results presents the participants' etiological beliefs about the causes of mental illness. To assess the beliefs about the causes of mental illness, the participants were asked about their beliefs about the causes of abnormality, their responses were mostly traditional beliefs such as: witchcraft' angry ancestors; ancestral calling; a need of traditional rituals and evil spirit. These responses were then grouped into three categories namely animistic; magical; and mystical aetiology. Subsequently the last part of this section presents the results concerning the link between the beliefs about the aetiology and conception of mental illness.

5.4.2.1 BELIEFS ABOUT THE CAUSES OF MENTAL ILLNESS

A. ANIMISTIC AETIOLOGY

Many participants in this group believed that a person can have psychological challenges as a result of refusing ancestral calling ukuthwasa in isiXhosa. Furthermore, one of the participants mentioned the term that they refer to ukuthwasa with as traditional healers and amaXhosa. Sizwe expressed that:

"okay, there are basically two reasons why a person is mentally ill, in terms of traditional healers a person might be psychologically disturbed because of ancestral calling, when a person has what we call Umshologu/ Ukuthwasa (the spirit of the ancestors)" (Interview 8, January 2019).

Similarly, Gugu one of the participants argued that being psychologically disturbed has to do with refusing to do certain traditional rituals, and as indigenous healers their role is to advise the person to perform those rituals. Gugu was quoted:

"As traditional healers we believe that being psychologically challenged might be caused by not doing certain traditions or rituals. In this case we would advise the person to do those traditional rituals. In other cases, the person might be mentally disturbed because they refuse to accept ancestral calling to become a traditional healer" (Interview 7, January 2019).

Furthermore, one of the participants argued that if people would accept and do what they ancestors require of them, they would not get psychological abnormalities, this then goes back to the enormously held believe that if the person has a good relationship with their ancestors they will protect the person from all evil and other factors that can harm the person. In relation to this, Bongi responded:

"Most of the time this happens when a person is not in good standing with their ancestors, sometimes when a person does not answer the calling of being a traditional healer, and because of that the person ends up being psychologically disturbed……I think if people were to do what the ancestors require of them, they would not get psychologically disturbed or sick for that matter" (Interview 6, January 2019).

B. MAGICAL AETIOLOGY

All the participants in this group believed that angry ancestors can be the cause of mental illnesses. The participants in their responses expressed that if the ancestors are angry; they turn their back on the person, and thus will not protect the person from malicious behaviour of other people and witchcraft. On the other hand, the participants also believed that if the person does not do certain traditional rituals or does them inappropriately that could lead to psychological abnormalities. For example, Gugu expressed that:

"In my own understanding as a traditional healer, what makes a person to be mentally ill is that if a person does not do traditions and rituals, in this case the ancestors will turn their back on the person and not protect them. In other cases, a person might be bewitched and gets mentally ill" (Interview 7, January 2019).

Similarly, the other participants also believed that bewitchment from a malicious and envious person can cause psychological disturbances, where the person uses harmful plants or herbs, and or powers to bewitch a person. In relation to this, Sizwe replied:

"okay, there are basically two reasons why a person is mentally ill, in terms of traditional healers a person might be psychologically disturbed because…on the other hand, it might be because a person was bewitched or is possessed by evil spirits, what we call Ishologu" (Interview 8, January 2019).

C. MYSTICAL AETIOLOGY

One of the participants believed that, psychological abnormality can be caused by the persons' actions or behaviour; this therefore implies that if you do something bad to another person and that person wishes you bad, *ukushwabula* in isiXhosa language or revenges your actions towards them. There is a possibility that mental illness can be caused by that. For instance, Gugu in her response stated:

"Maybe, a person once done something bad to another person, then that person says that I will get them, in other cases bewitch them or use evil medicine etc." (Interview 7, January 2019).

5.4.1.2 THE LINK BETWEEN THE BELIEFS ABOUT THE AETIOLOGY AND CONCEPTION OF MENTAL ILLNESSES

According to the responses of the participants, there was a strong relationship between their aetiological beliefs and the conception and understanding of psychological maladjustment. For instance, all the participants in this group believed that psychological challenges are caused by refusing ancestral calling; having a bad relationship with the ancestors; witchcraft, evil spirit; not executing traditional rituals, evil action of a person etc., and all of these are within the indigenous worldview of explanation of illnesses. Nevertheless, there was one participant who had Western sentimental views about the aetiology of mental illnesses, where he expressed that psychological challenges can only be treated by professional mental healthcare workforce unless the cause of the abnormality is related to indigenous tradition. Additionally, this participant expressed that only psychologist have the necessary means to treat a person who is psychologically challenged, and he would even advise the person to get western treatment in any illness that has to do with psychological wellbeing. Consequently, it can be assumed based on the results of this current

research that, the participants' view and conceptualisation of mental illness has a relationship with their aetiological beliefs.

5.4.3 AFRICAN TRADITIONAL INTERVENTION FOR PSYCHOLOGICAL DISTRESS

The indigenous strategies for healing are not kept to the utilisation of pharmacological medication, however the utilisation of traditional ceremonies as a method of correspondence with the progenitors shapes the foundation of African traditional treatment. In addition to that, the greater part of these rituals are of incredible remedial incentive to patients and the purpose behind this adequacy could be identified with the way that the mediations depend solely on the convictions of the patients, and hence corresponding with their perspectives (Melato, 2000; Sandlana & Mtetwa, 2008). The subsequent section discusses the results of the current study which are related to the African therapeutic methods or interventions which traditional healers and Xhosa people respectively use to treat health related problems including mental illnesses. The participants were asked questions like: what are the therapeutic methods used by the Xhosa people in treatment of mental illnesses, to get a full understanding of some of the treatment methods that are frequently and normally employed in the treatment of mental illnesses. The responses from participants were then grouped into three subthemes namely: African traditional medicine; African traditional divination; and African traditional rituals, these subthemes are discussed in the following sections.

5.4.3.1 THE AFRICAN TRADITIONAL MEDICINE

Many participants stated that in the process of treatment, African traditional medicine including different herbs, plants and mixtures is utilised as one of the therapeutic methods. Traditional healers continued and expressed that there are various indigenous remedies uses, and the kind of mixture one use depends on the illness; the cause; and the traditional healer him/herself. In addition to that, many participants argued that different remedies can be used for the same illness; this is because traditional healers are gifted differently and the treatment procedure is communicated, guided, and directed by the ancestors. Bongi was of the view:

"Traditional medicine helps a lot, especially if the cause of the illness is traditional. You use Xhosa traditional medicine and make sure that you take good care of the person you are treating and give them the appropriate traditional mixture which is related to their illness… no one per se

who teaches us about traditional medicines, rather we are given guidance by our ancestors through dreams and imaginations" (Interview 6, January 2019).

In the same sentiment, Sizwe stated that as indigenous healers they use different herbs and mixtures to treat the person, nonetheless their treatment procedure and medication is different to the psychopharmacological medication that mental health professionals use to treat mental illnesses. He argued:

"As traditional healers, we treat people who are psychologically challenged using a mixture of traditional herbs and plants. We do not use medication like doctors and or psychiatrists…. Yes, it is different we do not use medicine. We use a mixture of traditional plants to make treatment, and these plants you are given by your ancestors" (Interview 8, January 2019).

5.4.3.2 AFRICAN TRADITIONAL DIVINATION

All the participants had similar views about the Africa divination process. The participants in their responses mentioned divination as one of the methods that they use as indigenous healers in the treatment process. Additionally, participants expressed that the divination process entails a traditional healer to seek guidance and direction from the ancestors. Furthermore, the process of seeking guidance from the ancestors is usually done through different methods such as throwing of bones; the use of *isilawu* in isiXhosa etc. In addition to that, the participants stated that this process is of great importance and helps the healers and patients to know the cause of the illness. Gugu responded:

"There are various methods that we use as traditional healers, for instance, we use bones, were when a person comes to us as we throw bones and through those bones, we can see why a person is sick and other things. Other traditional healers seek guidance from the ancestors and the ancestors will be able to tell the cause of the illness. And other indigenous healers make use of what we call Isilawu in Xhosa, then the traditional healer will be able to read the message from Isilawu" (Interview 7, January 2019).

5.4.3.3 AFRICAN TRADITIONAL RITUALS

It is worth noting that many participants believed that psychological maladjustment can be caused by a person not doing certain traditional rituals, consequently those participants also believed that an execution of such rituals can treat the person of their illness, this is no exception to this group of participants. In relation to that, many participants in their responses stated that there are different traditional rituals that can cause a person to be mentally ill. The traditional healer in this case would advise the person and or the family of that person to perform a certain ritual, in addition to that, the participants argued that the execution of these rituals is guided and directed by them, with the guidance and direction of the ancestors. Such rituals can include appeasing to the ancestors; slaughtering a goat; going through the process of ukuthwasa etc., depending on the cause and the need of the ritual. Bongi was quoted:

"it depends, it might be that the person is called by their ancestors to become a traditional healer; in other cases the person get terrible headaches that do not succumb to any medication and they can only get helped by a traditional ritual. For instance, I am the one who was helped by traditional intervention instead of Western one. I used to have terrible headaches; the doctors tried every medication but did not work. All along the headaches I used to have was as a result of the calling by the ancestors to become a traditional healer" (Interview 6, January 2019).

5.4.4 PERCEPTION ABOUT THE ROLE TRADITIONAL HEALERS IN TREATMENT OF MENTAL ILLNESSES

Kahn and Kelly (2001) argue that, there are different kinds of African indigenous healers which Xhosa speakers recognise. Regardless of that, the generic term traditional healer is regularly employed to refer to every one of the categories. In this study, the term traditional healer is utilised to refer to the nonexclusive classification of African healers. To get an in-depth understanding of the role of traditional healers in treatment of mental illnesses, the traditional healers were asked such questions as: what is the role (s) of traditional healers in the treatment of mental illnesses; what kind of training did you receive to assist in treating mental illness; and what kind of people do usually use your services. Additionally, it was of great importance to get an immense understanding of the therapeutic methods that indigenous healers use, thus they were asked to describe their therapeutic methods when they are dealing with a psychologically challenged person. The following section will outline the results about the perception of traditional healers on

their role in the treatment of mental illnesses. In the quest of their perception, the participants were asked the role they have on treating mental illnesses. Furthermore, the section will outline the results on the experiences that the participants had in the treatment of psychological challenges.

5.4.4.1 TRADITIONAL HEALERS ROLE.

Many participants believed that they have an imperative role to play in the treatment of mental illnesses; the belief was however related to psychological abnormalities that are related to African traditions such as *ukuthwasa* (ancestral calling). Bongi responded and said:

"traditional medicine helps a lot, especially if the cause of the illness is traditional ... the way I was trained, was based on the fact that I had to understand the whole process, the understanding of knowing when a person is psychologically disturbed and how to treat them for a particular problem, because people have different needs and illness…the people who usually use my services are the ones who need help with things related to our culture, that is Xhosa culture…I would say to the people who have exhausted every means of help and could not find help. We as traditional healers we are also an option and they can get help from us. Traditional healers are of great help to people. Some people get mentally disturbed because they need a particular Xhosa traditional ritual, and some people might get illnesses such as asthma attack because they need to perform certain Xhosa ritual" (Interview 6, January 2019).

Correspondingly, Gugu one of the participants believed that they play a significant role in the lives of many people, especially in rural settings, nonetheless she mentioned that even people who are in urban areas do make use of their services. The participant further stated that, their services are not exclusive but anyone and everyone uses them regardless of their socio-economic class or status; literacy background; age and gender etc. In addition to that, many participants expressed that their role as traditional healers is to diagnose, guide and direct the treatment process. In the diagnosis process, the indigenous healers mentioned that they use different tools and methods to diagnose; one of those including throwing of bones, and the main reason behind diagnosis is to identify the cause of the illness. Gugu argued:

"There are usually many people who use my services, some people are working, and some are not working. What I mean is that, everyone uses my services irrespective of their status and economic

class…. indigenous healers work concerning helping people with mental illnesses, is to mix different herbs and plants to medication for the person and treat them. But before we treat the person, we first diagnose the person using our own tools and methods, so that we can get what is the cause of the illness, to other people the cause is the evil deeds of the person that they once did something bad to them; others it is because the person refuses to accept the ancestral calling of being a traditional healer and in this case, as traditional healers our duty is to advice the person to accept the calling and guide them through the whole process…..I myself was taught different traditional medicine, these can be used by different people with different healing needs, even for those who are mentally ill" (Interview 7, January 2019).

Contradictory, one of the participants believed that, if the person is psychologically disturbed, they have no role in treating that person but to advise the person to go to a psychologist. He further stated that, they do not have the necessary means to treat the person who has psychological abnormality. However, he also had similar sentiments with the other participants, that if the aetiology of the illness is associated with tradition, they therefore have a significant role to play in the treatment of that person. In addition to that, he argued that as traditional healers their role is look at the cause and thereafter treat the person in relation to the aetiology of the illness. Sizwe responded:

"In the case of a psychological disturbed person, I would advise the person to go to psychologists because I believe we do not have the necessary means to treat the person who has psychological challenges, unless the cause is related to tradition like in the case of ukuthwasa (ancestral calling)….. So, as traditional healers we look at what is the cause, now that a person is mentally disturbed. We can also assess the different causes in terms of how that person behaves. For instance, if the person behaves in a reckless way; imposes dangerous behaviours; distances himself/herself from other people, we can then say that a person is mentally ill because of evil spirits or is bewitched. In the case were a person has ancestral calling, they would usually say that they had dreams; they frequently have headaches such symptoms are that of ancestral calling" (Interview 8, January 2019).

5.4.4.2 THE ROLE OF ANCESTORS IN THE TREATMENT PROCESS

All the participants expressed that the ancestors have an immense and significant role to play in the treatment process, and the lives of people in general. Traditional healers were of the view that they cannot begin to work without consulting and connecting with the ancestors, and everything that they do is guided and directed by them. In addition to that, the indigenous healers expressed that they connect and communicate with the ancestors in various forms which include but not limited to dreams and imaginations. For instance, Gugu responded:

"In this case, we as traditional healers and other mental health professionals can play a significant role, in that, traditional healers work with the ancestors they direct and guide us. The professionals do what they have been taught and trained to do…. We as traditional healers have an important role to play. Many people do consider the traditional healing and believe in ancestors. Even when I look in the future, indigenous healing would still be of great use and importance. We might have not been educated, but the ancestors are our educators in everything that we do. For instance, they communicate with us through dreams, where they would indicate what plants and herbs to use for certain reasons. Or even you might have imagination which guides you on what to do" (Interview 7, January 2019).

In the same way, Bongi one of the participants mentioned that the ancestors guide them with the gathering of African herbs and plants for the treatment procedure. Furthermore, she stated that each healer has different therapeutic method that they are given by their ancestors; this therefore implies that every indigenous healer is different in their approach to healing and treatment. Bongi was quoted:

"In as much as the therapeutic methods and approaches differ, because people are gifted differently. A person and a person are given different traditional approaches to treatment; the illness might be the same but each and every traditional healer has their way of treating it. So, each and every healer is given by their ancestors, traditional medication that they cannot share with any other person" (Interview 6, January 2019).

5.5 DISCUSSION OF THE RESULTS

5.5.1 UNDERSTANDING AND CONCEPTUALISATION

Table 5.1: Conceptualisation & understanding of mental illness & psychological wellbeing.

Conceptualisation and understanding:	**Example of responses**
Mental illness	Abnormal & unacceptable behavior; disturbances in thinking process & mind; loitering around the streets; related to societal norms; need traditional rituals; refusing ancestral calling; imposing danger to others and yourself;
Psychological wellbeing	Proper functioning of the brain; behaving in a proper & acceptable way; mind is working congruently with other aspects e.g. physical and spiritual aspects; involves customs and norms e.g. bathing; proper development; good standing with the ancestors

According to Abdullah and Brown (2011) **s**ociocultural standards and customs help us figure out what practices and behaviours to think about as typical, which to think about as odd, and which may signify psychological instability. For instance, it might be acknowledged and seen as ordinary or even perfect in certain Middle Eastern societies to have dreams and hearing voices, meanwhile in most Western societies, such events would be ordered as hallucinations characteristic of significant psychological instability. In addition to that, behaviours are also judged abnormal if they are dysfunctional either for the individual or for society. For instance, it is argued that behaviours that interfere with a person's ability to work or to experience satisfying relationships with other people are likely to be seen as maladaptive, and this supports the current research findings. The research findings from this current research suggests that psychological challenges are indeed related to sociocultural norms, many participants from both groups of participants conceptualised and understood psychological abnormality in relation to social and cultural norms. Furthermore, Research findings from this study suggest that there are ingrained ideas of individuals with abnormality as being perceived as imposing danger to themselves and others; impulsive behaviour; and unpredictable, these find tentative evidence in the work of Corrigan et al., (2004); Corrigan et al., (2014); and Crisp et al., (2010). For instance, in light of the research led by Crisp

et al., (2010) the results propose that around 70 percent of respondents identified people with psychological illnesses as dangerous to other people and 80 percent saw them as impulsive or unpredictable. In conjunction to that, the results from this study suggest that many of the participants viewed and described people with mental illnesses as violent or danger to themselves and others; unclean; and roaming and loitering around the streets.

5.5.2 BELIEFS ABOUT THE CAUSES OF MENTAL ILLNESSES

Table 5.2: Beliefs about the causes of mental illness and participants responses.

Categories of aetiological beliefs	Example of responses
Animistic	Angry ancestors; refusing ancestral calling *(ukuthwasa)*; not doing certain traditional rituals e.g. *Imbeleko; circumcision* etc.
Magical	Bewitchment; Sorcery; Evil deeds of other people; evil spirit.
Mystical	Conduct or behaviour of the person e.g. *isimnyama*
Psychosocial factors	Drug and alcohol abuse; accidents and trauma; poverty, unemployment; childbirth; dysfunctional families; imbalances in the society.

Africans unequivocally believe in their ancestors and are committed to their obligations towards them. In the African worldview wellbeing is seen as a balance between the individuals and their hereditary spirits, accordingly, wellbeing is seen as a compensation for reverence and sacrifices made to the ancestors meanwhile illness and misfortune are viewed as discipline and or suggestion to reconnect with them (Bereda, 2008; Melato, 2000; Sandlana & sMtetwa, 2008). In addition to that, when the illness attacks a person, it induces the quest for the aetiology of the illness, including why the individual has been influenced in that specific way and time, and illness is regularly ascribed to three significant effects on the human condition namely, a supreme deity or God; the ancestors; and witches or sorcerers. In addition to that, this is an African perspective of illness and it is the general manner by which indigenous healers distinguish the reasons for ailment and treatment thereof (Austin et al., 2014; Kometsi, 2016; Melato, 2000; Shizha & Charema, 2011).

Furthermore, sociocultural history, customs, and beliefs which differ both crosswise over and within cultural groups, help us to know a groups' governing convictions in regard to individuals with psychological maladjustments. Many participants from this current study were not different in their understanding and conceptualisation of mental illness and the beliefs about the aetiology of mental illness. In addition, the participants from this study further recognised a number of cases that were related to ancestral issues. The results from both groups of participants suggest that there is a strong belief in the ancestors and psychological challenges. A number of participants believed that a bad relationship with the ancestors can cause abnormality, and that angry ancestors turn their back to protecting the person from harmful events and objects. In addition to that, the results indicate that the ancestors will thus need to be appeased and revered; such can be done through slaughtering of a goat, performing the necessary traditional rituals etc.

On the other hand, the differentiation among black magic and witchcraft, the two of which are referred to by the term *ukuthakatha* in IsiXhosa language, is obscured in idea and practice. Black magic is an intrinsic intuitive power accepted to be crafted by people with desirous, malignant and dangerous aims to cause illness, though sorcery is the utilisation of different substances from plants, creatures, and people as toxin to hurt a person (Hirst, 2005; Melato, 2000). In relation to the African worldview of illness and health, magical theories explain illness as a purposeful demonstration of a malevolent individual who uses enchantment to hurt the intended person, and sorcery or black magic are the fundamental techniques used to induce the ailment (Melato, 2000). In support of this view, the research findings from this current study suggest that, Xhosa people also believe that wizards and witches distinctly, may cause an illness using their damaging and magical spirits, and these findings find support in work by different researchers such as; Kometsi (2016); Melato (2000); Shizha & Charema (2011); and Thabede (2008).

The ailment causation is regularly comprehended by Africans through the all-encompassing logical model dependent on the conviction that congruity must exist inside the body and among individuals and the psychical condition. In relation to the African worldview, the person is understood and viewed holistically, where not only the physical aspect is considered, but the mind, soul and other aspects are considered in the health of a person. In addition, the relationship that a person has with ancestors; family and nature is also acknowledged, and all of these aspects are considered to be interconnected to each other, thus a person is considered holistically in every

aspect (Nwoye, 2015; Ross, 2010; Sandlana & Mtetwa, 2008). The results from this current study also suggest that there is interconnection in every aspect of a person that needs to be and is considered in relation to health and illness, and in the treatment process. Many participants from both groups of participants believed that a good relationship with your ancestors and family leads to psychological wellbeing and health. In addition, when the person gets ill, the treatment process is holistic in nature involving not only the person, but the family and ancestors as well.

5.5.3 AFRICAN TRADITIONAL INTERVENTIONS FOR PSYCHOLOGICAL DISTRESS

Table 5.3 African therapeutic intervention for mental illnesses.

African therapeutic interventions:	**Example of responses**
African traditional medicine	Plants; roots; and herbs e.g. *Isilawu; Isiwasho*; *ibhotile; umxube etc.*; identified and given by ancestors.
African traditional rituals	Slaughtering of goats; *ukuthwasa* ceremony; *Imbeleko; ukuqaphula; ukuxhentsa;* traditional healer advises and help with execution of ritual;
African traditional divination	Appeasing and consulting the ancestors; throwing off bones; seeking direction and guidance from the ancestors;

The participants including the traditional healers proposed that there are many African traditional intervention methods traditional healers use in the process of diagnosis and treatment of illnesses. The results from this study demonstrate that indigenous healers are contended to give all the more socially fitting and comprehensive treatment for many African patients where Western professionals fall flat, and this is particularly so with the following studies (Kometsi, 2016; Melato 2000; Yen, 2000). The findings further recommend that the ancestors when they are neglected supposedly turn their backs, and pull back their assurance *(ukukhusela)* from, their relatives, presenting them to the malicious impacts of black magic. The participants further proposed that, when the ancestors have been supplicated and appeased, *ukungxengxezela* and *ukucamagusha* in IsiXhosa, their assurance guarantees the viability of the indigenous healers' treatment. These

findings are supported in the subsequent work by De Andrade (2014); Hirst (2005); Kahn and Kelly (2001); Kometsi (2016); and Mzimkhulu and Sumbayi (2006).

The African indigenous ceremonies include paying appreciation to the ancestors which are normally appeased to be present on ceremonial events with their living relatives. On account of slaughtering for a traditional ritual, the indigenous healer regardless of whether male or female, for the most part guides and advises the execution of the ceremony. Furthermore, the *ukuxhentsa* ritual dance is one of the interventions Xhosa traditional healers use, in the case of a person who is believed to have ancestral calling and other related illnesses. Melato (2000, p.15) describes *ukuxhentsa* "as a form of dance, which consists of the pounding of the ground, hand clapping and the beating of drums, and *ukuxhentsa* is used to restore the initiates' wholeness by bringing the worlds of human beings and their ancestors". In addition to that, this ceremonial results in a holistically revived psyche, mind, and consciousness. The *ukuxhentsa* ritual is also accepted to enact the sensory system in this manner stimulating the procedure of wellbeing and wholeness. Moreover, the research findings indicate that the method of bone-throwing is a widespread African traditional diagnostic method that indigenous healers utilise and through this process the healer is able to translate and explain the persons' symptoms and reasons for ailment using divination bones, these research findings are validated in the work of Kometsi (2016) Sodi, (2009); and Sodi and Bojuwoye (2011). Various participants communicated that this procedure is guided and coordinated by the predecessors and the ancestors are referred to in terms of reverence and respect *intlonipho* in isiXhosa language. In addition to that, the results recommend that traditional healers account immense sensitivity and reliability to dreams, *amaphupha or amathongo* in isiXhosa. For example, Hirst (2005) argues that there is no way a traditional healer would not go and gather traditional therapeutic plants *(iyeza)* in the bush or anyplace that was revealed to them in a dream or imagination, and utilise it to treat *(ukunyanga)* an individual.

5.5.4 PERCEPTION ABOUT THE ROLE OF TRADITIONAL HEALERS IN TREATMENT OF MENTAL ILLNESSES.

Table 5.4 perceived benefits of traditional healers in treatment of mental illnesses.

Perceived benefits of traditional healers:	**Example of responses**
The role of traditional healers.	Help with diagnosis; advice and help with the execution of traditional rituals; appease and communicate with the ancestors; guides the process of healing.
The role of the ancestors	Guide and direct traditional healers; communicate through dreams and imaginations; direct traditional healers with African herbs and plants.

The indigenous healers, *amagqirha* in the Xhosa language, are traditional diviners who intervene with familial shades, and utilise custom and African traditional mixtures of plants and herbs in the treatment process (Bomoyi, 2011; Melato, 2000; Thabede, 2008; Yen &Wilbram, 2003). African traditional treatment for the most part includes ceremonial execution and may incorporate traditional herbs and plants; and remedies. In different cases, the indigenous healer utilise African therapeutic plants, animal items (Kahn & Kelly, 2003; Melato, 2000). The indigenous healers utilise mystical powers to clarify adversity and sickness and offer direction on conciliating the ancestors (Kahn & Kelly, 2003; Kometsi, 2016). The outcomes from this research suggest that, African Xhosa traditional healers' information help in determination and clarification of the issue that the patient discovers, and that is increasingly satisfactory and more understandable to them. For instance, many participants from the current study recommended that traditional healers have an important and significant role to play in the treatment of mental illnesses. The participants suggested that indigenous healers' role is to help with the diagnosis; advice; and execution of traditional rituals for those people who the aetiology of psychological abnormality to be the need of executing Xhosa traditional rituals, and these findings find support in the work of Kahn and Kelly (2003); Melato (2000); Struthers et al., (2004); and Thabede (2008). For instance, Melato (2000) argues that to this day and time, African indigenous healers guarantee that individuals perform the recommended traditional ceremonies in a proper way so as to conciliate the ancestors. In addition, the ceremonies structure the premise of the connection between individuals and their

ancestral soul. The current research findings suggest that there are various Xhosa traditional rituals that traditional healers help with and guide the process of doing such rituals. The participants in their responses mentioned *ukuxhentsa* ritual, *ukuthwasa*; appeasing to the ancestors; sacrificial slaughtering; *ukuhlamba*; *ukuqaphula; Imbeleko etc*., and these findings corroborate with the work of many authors such as Hirst (2005); Melato (2000); and Kometsi (2016).

African indigenous healers are recognised for their phenomenal knowledge of narratives, their cultural language; religious aspects, methods of reasoning, and different collections knowledge (Austin et al., 2014). In relation to that, indigenous healers are recognised as an important part of the lives of many, especially in rural settings. Furthermore, indigenous healers are acknowledged for their help with diagnosis, where patients would be seeking answers to what is the cause of the illness (Nwoye, 2015; Thabede, 2008; Yen, 2000). The findings from this research, propose that indigenous healers help with the diagnosis process, where they will seek guidance and direction from the ancestors through different methods and tools. The participants from both groups enormously believed that any work of a traditional healer is under the guidance of the ancestors, and no work begins without consulting and communicating with the ancestors. Additionally, the diagnosis process was acknowledged to be a very helpful procedure not only by the general participants but the traditional healers as well, they believed that the diagnosis helps with knowing the cause of sickness and therefore the procedure thereof.

5.5.5 THE ISSUES RELATED TO HELP-SEEKING.

Table 5.5 Issues related to help seeking for mental health care.

Issues related to help seeking	**Examples of responses**
Access to mental health care	Insufficient resources; unavailability of mental institutions; difficulty accessing mental healthcare institutions e.g. distance; transport fare etc.
Other barriers to help seeking	Language; lack of knowledge & education; different worldviews and paradigms; different belief systems and cultures;

The data from cross-national indicators in Brazil, Chile, India and Zimbabwe demonstrate that normal mental issues are about twice as continuous amongst the poor as compared to the rich. In

addition to that, the findings likewise recommend that the course of dysfunctional behavior is induced by the financial status of the individual and this might be after effects of administration related factors including difficulties accessing psychological health. In such manner, Patel et al., (2007) affirms poverty to be one of the hazard components of psychological wellness. Moreover, the literature recommends that developing areas have few apportioned resources for emotional wellness and much of the time these resources are inaccessible to the less fortunate (WHO, 2001). In relation to that, Melato (2000) argues that, the availability of traditional healers to many rural social settings provides an alternative type of treatment to many people who do not have access to the Western psychological health facilities and institutions. Furthermore, understanding indigenous recuperating strategies and the social structures it draws from, would be boundlessly helped by familiarity with the language that shapes these services, correspondingly, the differences in these services is exacerbated by the conspicuous problem posed by most of emotional well-being experts' failure to communicate in any African dialects (Yen, 2000).

The research findings from this current research suggest that accessing mental healthcare for people who are in rural areas is mostly difficult and sometimes impossible. Many participants mentioned in their responses that in their community there are no mental health institutions, the institutions are only in surrounding urban areas and towns, even so, it becomes difficult for them to access these institutions because of various reasons that are related to poverty and associated conditions of unemployment; low educational level. These findings corroborate the findings in the work of (Gulliver, Griffiths & Christensen, 2010; Mkhize & Kometsi, 2008; Swartz et al., 2006). In addition to that, many participants expressed that language is amongst the other barriers to seeking help for mental health problems. It becomes difficult for them to communicate and express themselves in a sound and appropriate manner when differences in language are concerned. In relation to that, there is tentative evidence that supports these findings (Kung, 2004; Verdinelli & Biever, 2009). Furthermore, the results from this study also suggest that the differences in worldview and philosophies of the client and mental health professional hinders some people to help-seeking, where there are differences in belief system be it social and cultural norms and so forth, and these findings find support in the work of (Kometsi, 2016; Leong & Lau, 2001).

5.6 CONCLUSION

In conclusion this chapter of the current research study outlined and discussed respectively the research findings for this study. The chapter firstly outlined the results of the study, were the responses of the participants were thematically analysed and were grouped into themes. The results of this research were outlined and presented into two groups. Subsequently, the chapter discussed the results in the section that followed, were the tables were used to summarise the responses of participants and discussion of the results. It is clear from the outcomes that were exhibited that mental issues are common and are a significant weight on human healthcare services, and the weight is presumably more prominent than the limit of any individual wellbeing administration. And thus, the topic of proper and appropriate healthcare services turns is critical and important. Accordingly, indigenous healers give a conception and understanding of African patients' sociocultural setting, were illnesses such as hearing voices and faith in spirits are not erroneously considered as an indication of mental ailment. In addition to that, sociocultural procedures give an alternative framework of traditional healing that works in equivalent to the other healthcare services, and patients regularly utilise the two frameworks for tackling their health-related issues.

CHAPTER SIX: LIMITATIONS, RECOMMENDATIONS, SUMMARY OF FINDINGS, AND CONCLUSION

6.1 INTRODUCTION

This research study explored an in- depth understanding and conceptualisation of traditional African worldview of mental illness and psychological wellbeing with IsiXhosa speaking people, this was done through conducting in-depth interviews with two groups of participants. The first group included the general population which was sampled using purposive sampling technique and the second group of participants included interviews with three traditional healers. In addition to that and for the purposes of accomplishing the objectives of the research, the study explored the utilised traditional healing systems for mental health problems and the role indigenous healers have in the treatment process. The sample of the study was drawn from Amahlathi local municipality of the Amathole district in Keiskammahoek region using purposive sampling. The total number of participants that were interviewed was eight IsiXhosa mother-tongue speakers residing in Keiskammahoek, and the sample consisted of both females and males between the ages 35-60 years. This current chapter provides the limitations that occurred while conducting the study, in the subsequent section there is an outline of the summary of research findings and this summary is depicted using a table. In addition to that, the chapter provides the recommendations for future research studies and thereafter a conclusion of the research study is provided.

6.2 LIMITATIONS OF THE RESEARCH STUDY

The current research study had various and many limitations, it is therefore important that when interpreting the research findings of this research these should be taken into consideration. Nonetheless, this current study provided meaningful findings concerning the participants understanding and conceptualisation of mental illnesses and psychological wellbeing; the aetiological beliefs about the causes of psychological abnormality; the African traditional healing systems for mental illnesses and the role traditional healers play in the treatment of psychological challenges. In addition to that, the objectives and aims of this research were met regardless of these limitations.

(a) Firstly, as a result of immense data from the interviews conducted and data saturation purposes, the researcher did not conduct a large number of interviews. Therefore, the findings of this research are not a full representation of the population of Keiskammahoek

or the Amathole district. A small sample of the population was drawn from the residents of Keiskammahoek, Amahlathi local municipality of the Amathole district. Consequently, a larger sample would be much better for validity and reliability purposes.

(b) Secondly, the Keiskammahoek area is a diverse community in relation to race, ethnicity, age, and culture. However, for the purposes of meeting the objectives and aims of this current research, the focus was mainly on Xhosa residents between the ages 35-60 years of age, and this meant excluding other races, ethnicities, age groups and cultures. In this regard, the study is limited to only Xhosa peoples' understanding of psychological abnormality and normality, and to the Xhosa people's cultural practices and interventions to the problems related to mental healthcare. Therefore, the findings from this study are not a representation of other racial, cultural, and ethnic groups. In addition to that, the age group aspect should also be taken into consideration when interpreting these findings.

(c) Thirdly, this limitation relates to the sample or finding participants for the study. A sample was drawn using purposive sampling technique. The study did not comprise of many male participants, which resulted to having only three male participants in conjunction to five female participants. The smaller number of male participants might have compromised the research findings.

(d) Lastly, the use of English language while conducting the research, this relates to some participants misunderstanding and misinterpreting the interview questions. Unrelatedly, the interviewer was able to conduct some of the interviews into isiXhosa language.

6.3 SUMMARY OF FINDINGS

Table 6. 3 Summary of findings for the current research project

Main themes	Summary of findings
1.Understanding and conceptualisation	**a) Mental illness:** most participants understood and conceptualised emotional distress in relation to behaviour, sociocultural norms and thinking processes. For instance, a person who is mentally ill, was conceptualised and understood to have disturbances in the thinking process, inability to act congruently and unconscious; inability to behave in a normal and acceptable way in the sociocultural setting.

	b) Psychological wellbeing: many participants conceptualised psychological wellbeing as being in congruence with life, behaving in an acceptable and appropriate way, and being conscious and having a normal state of mind. Additionally, the person who is mentally well was believed to have a sound relationship with their ancestors; world; and their environment
2.Beliefs about the cause of mental illnesses	**a) Beliefs about the causes of mental illness:** the results from the study suggest that many participants have certain beliefs about the aetiology of psychological maladjustment, and these beliefs were mostly related to explanatory theories of mental illness and health. The beliefs about the causes of mental illnesses included animistic, magical, and mystical theories. Nonetheless, there were few participants who indicated and believed that certain psychological abnormalities can be caused by psychosocial factors such as drug and alcohol abuse; dysfunctional families; childbirth; unemployment etc.
	b) The link between the beliefs about the aetiology &conception of mental illnesses: the results from the study clearly suggest that there is a relationship between the participant's beliefs about the causes of mental illnesses and their conceptualisation of psychological distress. The participants, who mostly believed that mental illnesses are caused by African related factors, had an understanding of mental illness that is related to the African worldview. For instance, this understanding was associated with a broken relationship with the ancestors; angry ancestors; the need to do certain traditional rituals; ancestral calling and more. In the case of the participants who also had a Western related believes about the etiology of mental illnesses, there was as well a strong link in terms of how they understood and conceptualised mental illness, this included the thinking process, consciousness, and behavior.

3.African traditional interventions for psychological distress	**a) African traditional medicine:** the findings suggest that African traditional healers utilise indigenous plants and herbs to make traditional mixtures. This was suggested by many participants as a method that traditional healers use to help people who are ill, including those who have psychological abnormalities.
	b) African traditional divination: many participants including the traditional healers stated traditional divination as one of the methods they use in the treatment process. This process was said to be very important as it brings about answers as to why a person is sick; and who made them sick and more.
	c) African traditional rituals: a number of participants suggested that traditional healers use traditional rituals as one of the methods to healing. The traditional rituals are guided and directed by the indigenous healer under the authority and guidance of the ancestors. Participants stated that these rituals are may include slaughtering a goat to appease to the ancestors; ukuthwasa ritual; incision to protect the person from witchcraft; cleansing ceremony; and many more.
4.Perception about the role of traditional healers in treatment of mental illnesses	**a) The role of traditional healers:** numerous participants believed that traditional healers have and important and enormous role in the treatment of mental illnesses. The role is related to advising and guiding the treatment process, in addition to that divining and helping with the reasons for the illnesses and more. Nevertheless, there were participants who had a contradictory view about the role of traditional healers. These participants believed that indigenous healers have no role to play in the treatment of mental illness and would therefore recommend mental health professionals to intervene in this process unless the aetiology of the illness is a caused by traditional related matters.

	b) The role of the ancestors: most participants believed that the ancestors have a huge and vital role to play in the treatment process; infact the participants believed that the treatment process is guided and led by the ancestors. Therefore, the traditional healers need to seek guidance and communicate with them before anything.
5.The issues related to helpseeking	**a) Access to mental health care:** most participants in their responses stated that, it is difficult for many people who are in rural areas to access mental health institutions because there are no mental hospitals in their areas. Consequently, many people from these settings loiter around the streets without any form of help; the participants also stated that this was the case in their community. Furthermore, in the surrounding or close urban areas it becomes difficult and sometimes impossible for them to go to those institutions as a result of transport costs and other related factors.
	c) Other barriers related to mental health care: several participants suggested that there are many other barriers which lead to not seeking help for mental problems, these included but are not limited to language; different worldview and sociocultural beliefs between the client and mental health professional.

6.4 **RECOMMENDATIONS**

The findings of this current research study were outlined and discussed in the previous chapter; consequently the recommendations for this research study will be based on the findings of this study. The research findings revealed that, there is a shortage of mental health care institutions, especially in rural settings such as the Keiskammahoek area. People who are in need of psychological services frequently do not have readily available access to these services because of various constraints such as costs to accessing mental healthcare; lack of knowledge of such services; distance that people in rural areas have to travel to access these institutions and other relative factors. It is therefore recommended that there should be awareness campaigns which will educate people about mental healthcare, and the focus of these campaigns should be to bridge the

gap of illiteracy and inadequate knowledge of psychological problems, in addition to educate people about psychological abnormalities in relation to natures; detection; aetiology; and treatment processes. Furthermore, the government local and provincial should place much emphasis on mental healthcare in rural areas and provide resources that will enable people to have easy access to such services; this will in turn aid to address the issues of unequal distribution of resources.

The study as well highlighted the differences that people have in relation to the understanding and conceptualisations of psychological abnormalities; these were recurrently related to the causes associated with mental illnesses, and the cultural background and context. It is recommended that, there should be interventions that would focus on the diverse nature of the people in the Eastern Cape Province and in general. Moreover, these interventions of mental healthcare should focus on the promotion of alternative mental healthcare, were people's aetiological beliefs and understanding of mental illnesses are accepted and not be rejected.

The research findings of this study also suggest the issues that are related to mental healthcare which are frequently associated to the differences of worldview between the client and the professional including cultural background, belief systems and practices. In relation to that, the current research recommends that there should be future research study that will focus on the understanding of different worldviews for psychological abnormalities. These research studies should be conducted in a denser way, which might include using triangulation of research designs, because this study only used a qualitative research design. In addition to that, there should be also research studies that will focus on the collaboration between traditional and mental health practitioners, this will help to get an in-depth understanding of both practices and in turn contribute to the body of knowledge. Furthermore, the collaboration will also aid in the exchange of different knowledge systems; this will help in the different understandings and conceptualisations of various mental illnesses and the meaning that is attributed to these illnesses by Western professionals and traditional healers.

6.5 **CONCLUSION**

There are different conceptualisation and understanding of psychological distress and wellbeing, as a result of various sociocultural settings; the stereotypes and different worldviews that people adhere to. Consequently, the need to have an in-depth understanding of the different worldviews relating to the public's conceptualisation and understanding of mental illness and psychological

wellbeing is important for public and as well the mental healthcare professionals, so as to redress and improve the issue of mental health illiteracy and other related factors. In addition to that, it is as significant to understand the different treatment methods that people use and mostly prefer in cases of emotional distress. Many people who have psychological abnormalities are frequently unaware that there are effective mental health institutions for such problems because of poor psychological health literacy and other related factors. In other cases, an enormous number of people is reported to not have easy access to mental healthcare for a number of reasons included limited resources in their communities including mental health care and the unavailability of mental institutions within and close proximity to them, consequently this results to people who are without help especially in rural settings. Many studies have substantiated that the public has poor mental health literacy and that people in different and within the same sociocultural settings have various conceptualisation of mental illness and psychological wellbeing. Furthermore, many research studies have confirmed that people predominantly have an understanding of psychological abnormalities as being associated with Western worldview. In addition to that, their beliefs about the aetiology of mental illnesses are frequently attributed to biopsychosocial factors. Nonetheless the results from this study suggest that many people do endorse a different understanding and conceptualisation of psychological distress and wellbeing that is contradictory to that of Eurocentric psychopathology. Furthermore, their views about the causes of mental illnesses are related to the indigenous explanatory models. The current study explored the African worldview of mental illness and psychological wellbeing amongst the isiXhosa-speaking of the Eastern Cape Province. The study was conducted in Keiskammahoek surrounding areas, at the Amahlathi local municipality of Amathole district.

Appendix 1(a): Informed consent (English version)

School of Applied Human Sciences,

College of Humanities, Howard College Campus.

University of KwaZulu-Natal.

Dear Participant

INFORMED CONSENT FORM TO BE SIGNED BY PARTICIPANT

TITLE: Exploring the Indigenous African worldview of mental illness, psychological well-being,and traditional healing systems amongst the rural IsiXhosa-speaking of the Eastern Cape.

My name is Sophumelela Tontsi. I am a Master of Social Science (Psychology) student, studying at the University of Kwa-Zulu Natal, Howard College campus, South Africa. My research study is about exploring and getting an in- depth understanding and perception of Traditional African worldview of mental illness among the IsiXhosa speaking people. To explore the meaning of psychological well-being within the African worldview and understand the traditional healing systems for mental health problems, amongst the IsiXhosa speaking people of Keiskammahoek, Eastern Cape Province.

I understand that everything that I share in the interview will be kept confidential.

- I understand that participating in this research study is completely voluntary, and at any given point of the research I can withdraw without giving reasons for my withdrawal.
- The interview will approximately be 30-60 minutes.
- I agree or disagree with the use of audio equipment during the interview.

AGREE	DISAGREE

- The audiotapes from the interview will be stored safely, so that no one besides from the research team will access information shared by you.
- I understand that my data will be stored and may be destroyed after 5 years.

- I understand that the information shared will not be used against me and will only be used for academic purposes.

I hereby agree to participate in the research study which aims to:

1. To explore participants' understanding of mental illness.
2. To explore participants' perception of psychological well-being.
3. To explore participants' healing or treatment methods for mental health problems.
4. To understand the role of traditional healers in treating mental health problems.

I have contact details should there be any further enquiries about the research study.

Group of participants…… Initials & signature…….

Place……. …… Date ……

1. **Contact details of principal researcher:**

   Sophumelela Tontsi

   Email: sophumelelatontsi@gmail.com

2. **Contact supervisor:**
   Mrs N.A Mtwentula-Ndlovu, School of Applied Human Sciences.
   University of Kwa-Zulu Natal, Howard College campus.
   Tell: 031 260 1087
   Email: Mtwentulan@ukzn.ac.za
3. **Contact details of research office:**

   Mr P. Mohun.

   HSSREC Research Office.

   Email: mohunp@ukzn.ac.za

   Tel: 031 260 4557

DECLARATION: English version

I …… (full names of participant) hereby declare that I understand the contents of this document and the nature of the research study, and I consent to participating in the research project.

I understand that participating in this research project is completely voluntarily, and at any given point of the research I can withdraw without giving reasons for my withdrawal.

Signature of participant:

……

Date:

……

Appendix 1(b): Informed consent (Xhosa version)

School of Applied Human Sciences,

College of Humanities, Howard College Campus.

University of Kwa-Zulu Natal.

IFOMU YOMTHATHI NXAXHEBA

Molo Mnumzana

Isihloko:Ukuhlola imbono ye sizwe yase Afrika yesifo sengqondo, ukuphila kakuhle ngengqondo, kunye nee nkqubo zokuphulukisa zemveli phakathi kwama Xhosa ase Mpuma Koloni.

Igama lam ndi ngu Sophumelela Tontsi. Ndingu mfundi owenza izifundo zengqondo kwiziko lemfundo ephakamileyo iDyunivesithi yaKwaZulu Natal, eHoward College Campus. Injongo yophando kukuba kuphandwe kwaye kuhlolisiswe nzulu ukuqonda nolwazi lwesizwe sama Xhosa ngezigulo zengqondo; ukuphila ngokwa sengqondweni; ukwenza uphando ngenkqubo zonyango lwemveli abantu bakwa Xhosa base Mpuma Koloni, bathi balusebenzise ukunyanga izigulo zengqondo. Ukongezelela, ukuqonda indima yezonyango zenkcubeko ekuphatheni izifo zengqondo, phakathi koluntu lwama Xhosa wakuQoboqobo, eMpuma Koloni.

Ndiyayiqonda into yokuba yonke into endizokuthi ndiyithethe kudliwano-ndlebe izokugcineka ngokukhuselekileyo.

- Ndiyayiqonda into yokuba ukuthatha inxaxheba kwam koluphando kukuzithandela.
- Udliwano ndlebe liyakuba malunga nemizuzu engamashumi amathathu ukuyela kumashumi amathandathu.
- Ndiyavuma okanye andivumi ukuba umphandi alucishilele oludliwano-ndlebe.

	NDIYAVUMA	ANDIVUMI
UCISHILELO		

- Umphandi uyaku qinisekisa ukuba ucishilelo lo dliwano ndlebe lukhuselekile, ukwenzela kungabikho namntu umnye ngaphandle ko mphandi nophathi wophando akwazi ukusebenzisa idatha.
- Ndiyayiqonda into yokuba idata izokugcinwa ngokukhuselekileyo, kwaye izoku tshabalaliswa emveni kwe minyaka emhlanu.
- Ndiyayiqonda into yokuba, ulwazi olufumaneka koluphando aluzukusetyenziswa ngenye indlela, ngaphandle kwe njongo yezemfundo.

Ndiyavuma ukuthatha inxaxheba koluphando onjongo yalo ikuku:

1. Phanda ulwazi ngezigulo zengqondo.
2. Phanda ulwazi no kuqonda ukuphilango kwengqondo.
3. Phanda iinkqubo zokuphulukisa zemveli phakathi kwama Xhosa ase Mpuma Koloni.
4. Ukuqonda indima yeenyangi zenkcubeko ekuphatheni izifo zengqondo.

Inkcukhacha ezilandelayo ungazisebenzisa, ukuba unemibuzo onayo.

Iqela lo mthathi nxaxheba…… utyikityo lo mthathi nxaxheba…….....

Indawo…… umhla…….....

1. Inkcukhacha zomphandi:

Sophumelela Tontsi

Inombolo: 072 5181 778

sophumelelatontsi@gmail.com

2. Ikcukhacha zomphathi:

Mrs N.A Mtwentula-Ndlovu

Inombolo: 031 260 1087

Mtwentulan@ukzn.ac.za

3. Inkcukhacha ze ofisi yophando:

Mr P. Mohun, HSSREC Research Office,

Email: mohunp@ukzn.ac.za

Inombolo: 031 260 4557

ISIBHENGEZO: Declaration (Xhosa version)

Mna**…….....** (igama elipheleleyo lo mthathi nxaxheba) Ngalo ondlela ndivakalisa ukuba ndiqonda okukulengxelo kwaye ndi yayayiqonda nenjongo nobume boluphando, kwaye ndiyavuma ukuthatha inxaxheba ko luphando.

Ndiyayiqonda into yokuba ukuthatha kwam inxaxheba kolu phando kungo kuzithandela, kwaye nangaliphi na ixesha ndinga kwazi ukushenxa ngaphandle ko kunika izizathu zokushenxa kwam.

Utyikityo lo mthathi nxaxheba:

……..

Umhla:

……

Appendix 2(a): Information sheet: English version

Research title: Exploring the indigenous African worldview of mental illness, psychological wellbeing, and traditional healing systems amongst the rural Xhosa people of the Eastern Cape.

Ethics committee number: HSS/2022/018M

Research Aims: The purpose of the research study is to explore and get in- depth understanding of and perception of mental illness with the Xhosa people. Moreover, to explore the subjective meaning of psychological well-being within the African worldview and to understand the traditional healing systems for mental health problems, amongst the Xhosa people of the Eastern Cape. In addition, to understand the role of traditional healers in treating mental health problems.

Method and duration: You will be interviewed using face to face semi-structured interviews with open-ended questions to explore the meaning and understanding of mental illness within the indigenous African worldview of Xhosa people. The interviews will be audiotaped and transcribed verbatim for the purposes of data analysis. The interviews will approximately be 30-60 minutes, however the allocated time for the interview maybe exceeded depending on the length and depth of your responses. The interviewees will be probed when it is necessary for further information about a phenomenon which is not understood. Probing will also be utilised to direct the discussion to achieve the objectives of the study and to increase the quality of your answers, to improved and comprehensive answers.

Potential risk: There are no potential risks for psychological; physical; and or emotional harm in this study. Nevertheless, should there be any experience of distress at any phase during the progression of the interview, please do inform the researcher/ interviewer. The researcher will take necessary steps to ensure that you are not harmed, be it psychologically; emotionally; and or physically. This will be done by liaising with the supervisor of the project, to provide necessary recommendations should there be any experience of psychological distress.

Potential benefits: There are no immediate and direct benefits to the participants and Keiskammahoek community. Nonetheless, the results from the study will contribute to the body

of knowledge related to mental health. The findings from the research study will contribute positively to the understanding of indigenous worldview of mental illness that would be helpful for mental health professionals to be open to cultural knowledge, with the directive to reduce misinterpretation and misdiagnoses of indigenous clients. In addition, the research study will benefit the community of Keiskammahoek in that, the findings will help to explain individual's subjective experience and conceptualisation of mental illness and psychological wellbeing, and the treatment(s) thus used for mental illnesses. This will thus yield vital information that can be utilised by the mental health care system within and thereof outside the community of Keiskammahoek. Furthermore, data will contribute to clients being met with mental health care that acknowledges them in their own context, and thus take cognizance of the cultural differences that characterize a multicultural country like South Africa**.**

Confidentiality: Confidentiality is employed in the study to protect you, by means of holding audiotapes from the interviews confidentially, and storing the data secretly from the public, and not releasing data in ways that will associate you to specific responses. The researcher will ensure that your name is not related with any information that you give, be it written or oral presentation and or on the discussion of research results. The researcher will ensure anonymity, by not disclosing your identity after data has been collected.

Withdrawal: You are voluntarily requested to participate in this research study. In agreement with the standards of informed consent, you have the right to end the interview at any time, and to refrain from answering any questions if you wish to do so.

Dissemination of research results: The data accumulated from the research will serve as fulfilment for a Masters Degree in Social Science (Psychology). A summary of the research findings and recommendations will be made available to the school of Applied Human Science Howard College campus, University of Kwa-Zulu Natal. In addition, should you wish to access the information you can contact the researcher and the research supervisor on the details provided. Moreover, after completion of the research project, the researcher will communicate with the councillor of Keiskammahoek community, in relation to the research findings. The researcher will ask the community leader to organize a community meeting, where the researcher will have a summary presentation of the research findings to the community at large, and or participants.

Appendix 2(b): Information sheet: Xhosa version

Isihloko sophando: Ukuhlola imbono ye sizwe sase Afrika yesifo sengqondo, ukuphila kakuhle ngengqondo, kunyene enkqubo zokuphilisa zemveli phakathi kwama Xhosa ase Mpuma Koloni.

Ethics committee number: HSS/2022/018M

Injongo yo phando:

Injongo yophando kukuba kuphandwe kwaye kuhlolisiswe nzulu ukuqondano lwazi lwesizwe sama Xhosa ngezigulo zengqondo; ukuphila ngokwa sengqondweni;ukwenza uphando ngeenkqubo zonyango lwemveli abantu bakwa Xhosa base Mpuma Koloni, abathi bazisebenzise ukunyanga izigulo zengqondo. Ukongezelela, ukuqonda indima yeenyangi zenkcubeko ekuphatheni izifo zengqondo.

Indlela ne xesha lophando:

Bonke abathathi–nxaxheba baya kudliwano-ndlebe. Udliwano ndlebe luzaku udliwano ndlebe liyakuba malunga nemizuzu engamashumi amathathu ukuyela ku mashumi amathandathu, nangona kunjalo, ixesha elibiweyo liya kuxhomekeka kwiimpendulo zabathathi nxaxheba. Udliwano ndlebe luyakucetyiswa xakuyi mfuneko ngolwazi olungaphezulu malunga nesimo esingaqondakaliyo. Ukuphononongа kuya kusetyenziselwa ukuqondisa ingxoxo ekufezekiseni iimpendulo zophando, kunye nokwandisa umgangatho wee mpundulo zabathathi nxaxheba.

Umngcipheko onokwenzeka:

Akukho mingcipheko yengqondo; ukulimala ngokwe mvakalelo nango kwenyama koluphando. Nango nakunjalo, ukuba kukhonaziphina iintlungu ezikuxinzelelisayo kusona siphina isigaba sodliwano-ndlebe, nceda uxelele umphandi. Ngokuqinisekilyo, umphandi uyakuthatha amanyathelo afanelekileyo ukuqinisekisa ukuba ukhuselekile. Umphandi uyakuthetha kunye nomphathi wesiphononongo ukubonelela ngeengcebiso ukuba ngaba kubakho uxinzelelo ngokwengqondo.

Inzuzo:

Akukho zibonelelo ezikhawulezileyo ne zihambelela nanqona bathathi-nxaxheba kunye noluntu lwaseQoboqobo. Nangona kunjalo, iziphumo ezivela kuhlolisiso ziyakunika isandla kumzimba wolwazi olunxulumene nempilo yengqondo. Iziphumo ezivela kwesisifundo ziza kunceda kakhulu ekuqondeni ulwazi lomthonyama lwezingulo zengqondo, eziyakuba luncedo kubaqeqeshi bezempilo yengqondo ukuba bavule ulwazi lweekcubeko, kunye nomyalelo wokunciphisa ukutolikwa nokuxilongwa kakubi kwezigulane. Ukongezelela, uphando luya kunceda uluntu lwakuQoboqobo ngokuba iziphumo ziyakunceda ukuchaza ukuqonda ukugula ngengqondo nokuphila ngokwa sengqondeni kwabantu, kwaye nonyango abalusebenzisayo ngokunjalo kwiingxaki eziphathelele nempilo yengqondo. Oku kuya kuvelisa ulwazi olubalulekileyo oluya kusetyenziswa kwinkqubo yokunakekelwa kwempilo yengqondo ngaphakathi nangaphandle koluntu lakuQoboqobo. I-data iyakubangela izigulane zidibane kunye nokunakekelwa kwempilo yengqondo ezibavumayo kumxholowazo, kwaye okukuqwalasela ukungafani kwenkcubeko ebonisa ilizwe elijongene neenkcubeko ezifanano MzantsiAfrika.

Imfihlelo:

Imfihlo isetyenzisiwe kwesisifundo ukukukhusela, ngokubamba intenthoyo dliwano-ndlebe kunye nokugcina idatha ngoku fihlakeleyo, kwaye nokunga khululi idatha ngendlela eyakukunxulumanisa kwiimpendulo ezithile othe wazithetha kudliwano-ndlebe. Umphandi uyakuqinisekisa ukuba igama lakho alinxulumenanga nalo naluphina ulwazi onikalona, nokuba lube ngomlomo okanye lubhalwe phantsi, okanye kwingxoxo yeziphumo zophando. Umphandi uyakuqinisekisa ukungaziwa, ngokunga khangeli ubunikazi bakho emvako kuba idatha iqokelelwe.

Urhoxiso:

abathathi-nxaxheba baya kucelwa ngokuzithandela ukuba bathathe inxaxheba koluphando, ngokubambisana nemiqathango yemvume yokuthatha inxaxheba koluphando. Unelungelo lokuphelisa udliwano-ndlebe nanga liphina ixesha, kwaye unemvume yokuphepha ukuphendula nayiphi na imibuzo**.**

Ukupapashwakwemiphumelayophando:

Idata eqokelelwe koluphando iyakuba yinzaliseko kwi-Masters degree kwinzululwazi yezeNzulu lwazi. Isishwankathelo seziphumo zophando kunye neengcebiso ziyakwenziwa ukuba zifumaneke kwisikolo se- Applied Human Science, kwi dyunivesithi yaKwa-Zulu Natal, Howard College Campus. Ukuba unqwenela ukufikelela kwiziphumo zophando ungaqhagamshelana nomphandi kunyenomphathi wesiphonongo kwiinkcukacha ezinikeziwe. Emvako kugqitywa kweprojekthi yophando, umphandi uyakuxoxisana nomphathi wakuQoboqobo, malunga ne ziphumo zophando. Umphandi uyakucela inkokheli yoluntu lwakuQoboqobo, ukuba iququzelele intlanganiso yoluntu apho umphandi uzakuba nesishwankathelo senkcazo yeziphumo zophando.

Appendix 3(a): Interview Schedule

DISSERTATION TITLE: Exploring the Indigenous African worldview of mental illness, psychological well-being, and traditional healing systems amongst the rural IsiXhosa-speaking of the Eastern Cape.

RESEARCH SUPERVISOR: Miss N.A Mtwentula-Ndlovu

GUIDING QUESTIONS:

GROUP ONE PARTICIPANTS

1. What understanding do you have of mental illness?
2. What do you perceive to be the cause of mental illness?
3. What does psychological well-being mean to you?
4. What are your thoughts about indigenous healing in general?
5. What is the healing or treatment method(s) of mental illnesses amongst the IsiXhosa speaking?
6. What is the role(s) of traditional healers in treatment of mental illnesses?
7. In your opinion, what do you think is the role of indigenous healers and ancestors (*Izinyanya*) in the mental health-care system?
8. Have you ever had any individual experience with an indigenous healer(s)? If yes, how did you find the experience?
9. As an African, what are some of the challenges that you perceive and or might have faced in being treated by western psychological services?
10. In your point of view, are there benefit(s) having a traditional healer providing services to mentally ill people?
11. Is your life more influenced by African values or Western values?
12. Thank you for agreeing to do this interview, is there anything else you would like to say?

GROUP TWO PARTICIPANTS: TRADITIONAL HEALERS

1. What are your perceptions regarding mental illness in relation to origin, existence and diagnosis?
2. How do you define mental illness?
3. What do you understand to be the cause of mental illness?
4. What is your understanding of psychological well-being?
5. What is the role (s) of traditional healers in treatment of mental illnesses?
6. What kind of training did you receive to assist in treating mental illness?
7. What kind of people do usually use your services?
8. What method(s) do you use to diagnose patients, and what role is played by the diagnosis?
9. What is the healing or treatment method(s) of mental illnesses amongst the IsiXhosa traditional healers?
10. What role(s) does a traditional healer play in treatment of mental illnesses?
11. Can you please describe your therapeutic method(s) when dealing with a mentally ill person?
12. In your view, what role would ancestors (*Izinyanya*) and indigenous healers play in an integrated health care system?
13. What value does indigenous healers in modern South Africa and in the future, have?
14. Thank you for agreeing to do this interview, is there anything else you would like to say?

Appendix 4(a): Request letter to gatekeeper

The Councillor

2 Maclean street

Stutterheim, Eastern Cape

4930

30 JULY 2018

Dear Mr D. Mzili

Request for permission to sample research participants within areas in and around Keiskammahoek.

I hereby request permission to sample a maximum of 12 participants from areas in and around Keiskammahoek town. The first group will comprise of a maximum of 8 participants will be sampled from IsiXhosa speaking residents of Keiskammahoek ages between 35-60 years. The second group of participants will be a maximum of 4 IsiXhosa speaking traditional healers around Keiskammahoek. The participants will be voluntarily requested to participate in the research study titled: ***Exploring the Indigenous African worldview of mental illness, psychological well-being, and traditional healing systems amongst the rural IsiXhosa-speaking of the Eastern Cape.***

The purpose of the proposed study is to explore and understand the perception of the Indigenous African worldview of mental illness with IsiXhosa speaking people. Moreover, to explore the meaning of psychological well-being and understand the traditional healing systems for mental health problems, amongst the IsiXhosa speaking of the Eastern Cape. To achieve the proposed research aim, the following objectives in the subsequent subsection were set. The criteria of the first group target sample are that the participants have IsiXhosa as their mother-tongue and be between the ages of 35-60 years female or males residing in Keiskammahoek. The criteria for the

second group target sample is that, they should have IsiXhosa as their mother-tongue, be traditional healers ages between 35-60 years females or males residing in Keiskammahoek.

All participants will be interviewed using face to face semi-structured interviews with open-ended questions to explore the meaning and understanding of mental illness within the indigenous African worldview of IsiXhosa speaking people. The interviews will be audiotaped and transcribed verbatim for the purposes of data analyses. The interviews will approximately be 30-60 minutes, however the allocated time for the interview maybe exceeded depending on the length and depth of the interviewee's responses. The interviewees will be probed when it is necessary for further information about a phenomenon which is not understood**.** Probing will also be utilized to direct the discussion to achieve the objectives of the study and to increase the quality of the participants' answers, to improved and comprehensive answers.

The researcher will verbally communicate rigorously all aspects of the study to participants, when they are first approached. The research study will adhere to the principle of voluntary consent that is the participants will only participate in research explicitly and freely. The participants will be asked to sign the informed consent form directly prior the interviews. This form will relate to issues of confidentiality, non-maleficence, and beneficence. In agreement with the standards of informed consent, it will be brought to the participant's attention, the right to end the interview at any time, and to refrain from answering any questions if they wish to do so. Confidentiality will be employed to protect the participants who are being studied by means of holding audiotapes from the interviews confidentially and storing the data secretly from the public, not releasing data in ways that will associate participants to specific responses. The researcher will ensure that participants' names will not be related with any information that they give, be it written or oral presentation and or on the discussion of this research. The researcher will ensure anonymity of participants, by not disclosing any participants' identity after information has been collected.

The data accumulated from the research will serve as fulfilment for the Master Degree in Social Science (Psychology). A summary of the research findings and recommendations will be made available to the school of Applied Human Science. Should the participants wish to access the information they can contact the researcher and the research supervisor.

Should you agree to grant me permission to access the participants from in areas around Keiskammahoek, May you kindly sign below to indicate your permission.

Regards

S. Tontsi

Researcher

Email: sophumelelatontsi@gmail.com

Contact: 072 5181 778

Signature …….

Date ……

Mrs. N. A. Mtwentula-Ndlovu

Research supervisor

Email: Mtwentulan@ukzn.ac.za

Contact: 031 2602 539

Signature …….

Date ……

Appendix 4(b): Gatekeepers letter

Amahlathi Local Municipality

OFFICE OF THE MUNICIPAL MANAGER
12 Maclean Street
Private Bag X4002, Stutterheim, 4930
Tel: 043 683 5000 Fax: 043 683 2907
Website: www.amahlathi.gov.za

To whom it may concern.

Dear Sir/ Madam

This letter is to confirm that I D. Mzili read the gatekeepers request letter dated 30 July 2018, from student 214549877 (Sophumelela Tontsi). I hereby give permission to the student to conduct research in areas around Keiskammahoek for only the reasons stated on the request gatekeeper's letter.

Regards: Full Names and Surname (Councillor of Amahlathi Municipality)

DUMISANI MZILI

Date: 2018.09.03

.....[redacted].....

AMAHLATHI LOCAL MUNICIPALITY

"Together for prosperity"

Appendix 5: Turnitin report

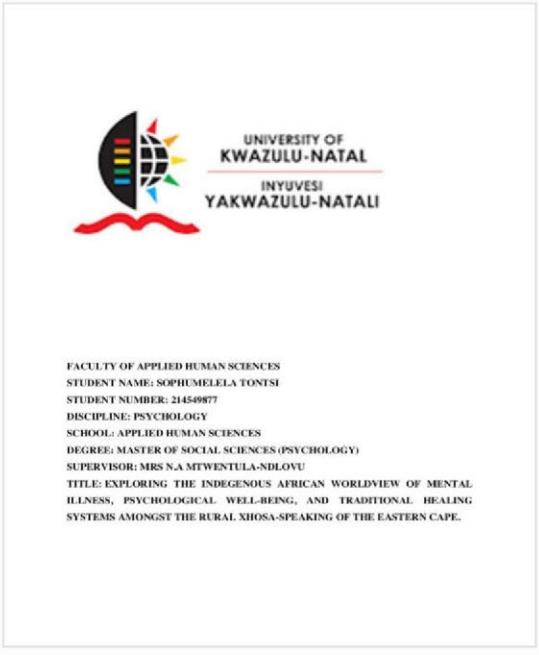
turnitin

Digital Receipt

This receipt acknowledges that Turnitin received your paper. Below you will find the receipt information regarding your submission.

The first page of your submissions is displayed below.

Submission author:	Sophumelela Tontsi
Assignment title:	Masters Counselling Psychology Re
Submission title:	final research paper
File name:	FINAL RESEARCH PROJECT.docx
File size:	382.56K
Page count:	136
Word count:	45,835
Character count:	265,742
Submission date:	29-Nov-2019 02:08AM (UTC+0200)
Submission ID:	1223415333



UNIVERSITY OF KWAZULU-NATAL
INYUVESI YAKWAZULU-NATALI

FACULTY OF APPLIED HUMAN SCIENCES
STUDENT NAME: SOPHUMELELA TONTSI
STUDENT NUMBER: 214549877
DISCIPLINE: PSYCHOLOGY
SCHOOL: APPLIED HUMAN SCIENCES
DEGREE: MASTER OF SOCIAL SCIENCES (PSYCHOLOGY)
SUPERVISOR: MRS N.A MTWENTULA-NDLOVU
TITLE: EXPLORING THE INDEGENOUS AFRICAN WORLDVIEW OF MENTAL ILLNESS, PSYCHOLOGICAL WELL-BEING, AND TRADITIONAL HEALING SYSTEMS AMONGST THE RURAL XHOSA-SPEAKING OF THE EASTERN CAPE.

final research paper

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UNIVERSITY OF KWAZULU-NATAL
INYUVESI YAKWAZULU-NATALI

19 December 2018

Ms Sophumelela Tontsi 214549877
School of Applied Human Sciences
Howard College Campus

Dear Ms Tontsi

Reference number: HSS/2022/018M
Project title: Exploring the Indigenous African worldview of mental illness, psychological well-being, and traditional healing systems amongst the rural Xhosa people of the Eastern Cape.

Full Approval - Full Committee Reviewed Application
With regards to your response received 13 December 2018 to our letter of 31 August 2018, the Humanities and Social Sciences Research Ethics Committee has considered the abovementioned application and the protocol have been granted **FULL APPROVAL**.

Any alteration/s to the approved research protocol i.e. Questionnaire/Interview Schedule, Informed Consent Form, Title of the Project, Location of the Study, Research Approach and Methods must be reviewed and approved through the amendment/modification prior to its implementation. In case you have further queries, please quote the above reference number. Please note: Research data should be securely stored in the discipline/department for a period of 5 years.

The ethical clearance certificate is only valid for a period of 3 years from the date of issue. Thereafter Recertification must be applied for on an annual basis.

I take this opportunity of wishing you everything of the best with your study.

Yours faithfully

[redacted]

Dr S Naidoo (Deputy Chair)

/px

cc Supervisor: Ms NA Mhuentual
cc Academic Leader Research: Dr M Mthembu
cc School Administrator: Ms A Ntuli

Humanities & Social Sciences Research Ethics Committee
Professor Shenuka Singh (Chair)Dr Shamila Naidoo (Deputy Chair)
Westville Campus, Govan Mbeki Building
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Website: www.ukzn.ac.za

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