THE TRADITIONAL HEALERS’ AND CAREGIVERS’ VIEWS ON THE ROLE OF TRADITIONAL ZULU MEDICINE ON PSYCHOSIS

by

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DEDICATION

To my mother and father, who made all this possible. Your sacrifices and struggles in shaping my life have not gone in futility. The humane aspect of me is a reflection of your selfless conduct towards me. My three older sisters have also played a fundamental role in making all this success.
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- Caregivers who shared their stories about the phenomenon investigated. You have played a major role in voicing people of the African ancestry’s understanding of psychosis and traditional medicine. This might benefit a number of Africans who come into contact with mental health care professionals.

I would also like to extend my special thanks to my extended family members, who have all contributed to my success.
DECLARATION OF ORIGINALITY

I, S.M. Makhanya (student number 200710398), declare that:

“The traditional healers’ and caregivers’ views on the role of traditional Zulu medicine on psychosis”

Is my original work and all the sources that were consulted and quoted have been acknowledged in the reference list.

S.M. Makhanya
2012
ABSTRACT

The focus of this research is in the area of the role of traditional Zulu medicine on psychosis. Such a study is important in order to have an in-depth-understanding of how people of the African ancestry conceptualise and treat a mental disorder such as psychosis. The research approach adopted in this dissertation includes qualitative content analysis. The findings of this research provide evidence that Traditional Zulu healers and a few community members view psychosis as a curable illness that is usually caused by bewitchment. This dissertation recommends that further in-depth investigation into how Africans tend to conceptualise the concept of a “mental disorder” be undertaken in order for this group of people to be better understood by mental health care practitioners whose approach is predominantly western. This might benefit both parties.
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CHAPTER 1
INTRODUCTION

1.1 Introduction

Psychosis is not a single entity but a psychological condition that takes different forms. Halgin and Whitbourne (2007, p. 278) asserted that these forms vary in a number of important ways, but share the core feature of a severe disturbance in the individual’s experience of reality about the self and the world. Feldman (2006, p. 538) offers a simpler and straightforward definition of schizophrenia, which is one form of a psychotic condition, as a group of disorders in which severe distortion of reality occurs. A more broader and all encompassing definition is offered by Halgin and Whitbourne (2007, p. 278), in which schizophrenia is conceptualised as a disorder with a collection of symptoms involving disturbances in form of thought, content of thought, affect, perception, sense of self, motivation, behaviour, and interpersonal functioning. These definitions are in line with how psychosis or schizophrenia, in particular; is conceptualised in psychology and psychiatry.

On the other hand, Sorsdahl, Flisher, Wilson, and Stein (2010, p. 284-290) conducted a study in Mpumalanga which consisted of in-depth interviews with Zulu traditional healers, the majority (60%) of which asserted that psychosis is not necessarily a mental disorder. Some of the traditional healers in that study asserted that the symptoms that people present with are inflicted on them by their ancestors as a calling to become traditional healers (Sorsdahl, Flisher, Wilson, & Stein, 2010). For example, these healers reported that the voices these people were hearing are linked to the instructions to accept the calling to become healers (Sorsdahl, Flisher, Wilson, & Stein, 2010). Moreover, healers in this study mentioned that there is more to the process of becoming a traditional healer than simply hearing voices (Sorsdahl, Flisher, Wilson, & Stein, 2010).

Other healers in that study mentioned that the symptoms that these people present with are caused by bewitchment (Sorsdahl, Flisher, Wilson, & Stein, 2010). Not all healers in that study believed that people who present with symptoms of psychosis are not suffering from a mental disorder; some of them agreed that these people have a mental disorder (Sorsdahl, Flisher, Wilson, & Stein, 2010). There were 50 participants in total in that study (Sorsdahl,
Fisher, Wilson, & Stein, 2010, p. 284-290). A good conceptualisation of psychosis from an African-Zulu perspective is captured in that research project, but questions around the role and effect of traditional healing methods on those who present with these symptoms (i.e. psychosis) remain open.

Studying human behaviour is so complex and cannot be compared to studying other non living objects because one needs to take into account their motives and the meaning they attribute to their behaviour in order to avoid being judgmental and to grasp the whole concept of what they are experiencing (Sivananda, 1990). Each person is born into a cultural context of existing beliefs, values, and cultural practices (Sue, Sue, & Sue, 2004). Individuals who share the same cultural matrix might exhibit similar values and belief systems (Sue, Sue, & Sue, 2004). Hook, Mkhize, Kiguwa, Collins, Burman, and Parker (2004, p. 25) maintain that a critical, emancipatory psychology, should take into consideration indigenous people’s languages, philosophies, culture and worldviews. Hook et al. (2004) further support their statement by asserting that this is because worldviews shape people’s attitudes, values and opinions, as well as the way we think and behave.

Some of the symptoms that are present in people who suffer from psychosis in western societies are also present in other individuals from non-western societies and these symptoms might not be regarded as indications of psychosis in the latter societies. For instance, Zimbabwean Shona cultural group regard visual and auditory hallucinations as spiritual experiences that are in line with the calling to becoming a traditional healer (Freshwater, 2006, p. 58). To be precise, psychosis does exist; however, people from different cultural contexts view it in different ways. In addition, what may be regarded, as symptoms of psychosis in one society may not be the case in the other one. Some studies provide a good insight about how symptoms of psychosis are conceptualised in different ways and mean different things to different societies (e.g. Freshwater, 2006; Canino, & Algeria, 2008). Nevertheless, less is said about the role of traditional Zulu medicine and its effect in dealing with symptoms of what is termed psychosis in the western societies or in a field like psychology and referred to as ukuhlanya or ukuphanjanelwa yikhanda in Zulu culture.
1.2 Statement of the Problem

A number of people who seem to present with symptoms of what may be termed psychosis from a western perspective, wander aimlessly and hither and thither in the streets of specific townships and rural areas. Some of these individuals present with some or all of the following symptoms: wandering away from home, walking aimlessly on the streets for a long period during the day; wearing same dirty clothes for days or weeks; wearing heavy blankets on hot summer days or many clothes on top of others; walking on bare foot for long distances; peeing in open public places without covering their private parts; picking obsolescent food from dustbins in nearest tuck-shops or shopping centres; walking undressed while making inappropriate laughter; seeming to converse with the wind as if hearing voices; if ever directing their conversation to another person the speech sounds incoherent. What the researcher perceives as a problem is the number of people who wander in the streets, and seem to present with symptoms of psychosis, yet there are Zulu traditional healers who have a social reputation that they can help or heal those who are suffering from this condition. What exactly is the role of Zulu traditional medicine in the lives of those who present with this condition in these specific societies?

1.3 Motivation

A scientist such as a psychologist may draw from a number of assumptions as causal factors of psychosis such as genetic predisposition, neural dysfunction, disturbed parent-child relationship, or biochemical factors (Kaap, 1991, p. 442-443). On the other hand, a person from a Zulu clan might assume that the sufferer had been bewitched. To support this view, Naidoo, Sehoto, and De Villiers (2006, p. 3) report that “AbaNguni (specific cultural groups from Southern African, of which Zulus are a part) occasionally are debilitated by a range of physical, social, psychological and economic ‘symptoms’ which imitate western diagnoses of physical and psychiatric disorders. These ‘symptoms’ arise in various combinations and do not respond to everyday traditional and western remedies. AbaNguni regard these presentations as being caused by supernatural entities”. Naidoo, Sehoto, and De Villiers (2006) mention witches (abathakathi) as one of the practitioners who might exert negative supernatural influences over other people. The researcher perceives these two different perspectives as predecessors to different treatment approaches. In this study, the researcher was interested in finding out if people who seem to present with symptoms of psychosis in streets of specific areas, are part of those who had previously consulted with traditional
healers. Moreover, it is to see how the outcomes or role of the medication or treatment approach received were.

1.4 Aims and Objectives

- The main aim of the study is to gain insight into the function or position (i.e. role) that traditional Zulu-medicine is expected to have in the lives of those who present with symptoms of psychosis.
- Secondly, the aim of obtaining the views of caregivers of people who once consulted traditional healers while suffering from symptoms of psychosis would be to further gain slight insight into the impact of the medication on their condition.
- Thirdly, the above information might enrich the field of psychology with new material or add on the already existing body of knowledge in this field about indigenous healing methods for community mental health.
- More importantly, community programmes might be later implemented by the researcher where exchange of information might be shared by both parties (i.e. community members and the researcher). The aim of this would be to broaden each party’s understating of psychosis, which may later generate broad and well-informed decisions about dealing with this phenomena, particularly in the Zululand area.
- Lastly, perhaps co-created culture-sensitive and culture-relevant interventions might be implemented.

1.5 Research Methodology

1.5.1 Target Population

“Target population is a group of prospective participants to whom the researcher wants to generalise the results of a study” (Welman, Kruger, & Mitchell, 2005). Welman, Kruger, and Mitchell (2005, p. 52) maintain that population encompasses the total collection of all units of analysis about which the researcher wishes to make specific conclusions. A sample, on the other hand, refers to actual participants drawn from the target population, which are assumed representative of the population depending on how they were selected. A sample of 8 Zulu-speaking traditional healers from Esikhawini Township and a rural area near Kwa-Dlangezwa (i.e. Ongoye) were interviewed. Four from Esikhawini and another 4 from Ongoye. In
addition, 2 caregivers of people who once consulted traditional healers while suffering from psychosis were also interviewed.

1.5.2 Design
“A research design is a plan for conducting research which is put into practice to attempt to find answers to the researcher’s questions and, therefore, a response to a chain of decisions about how best to answer focused questions or an arrangement according to which we obtain research participants and collect information from them” (Welman, Kruger, & Mitchell, 2005, p. 52). Content analysis was used because the researcher was looking for any frequently occurring common themes. Those common themes were words, sentiments and beliefs that participants constantly used or revealed during the interviews. The information from participants was acquired through interviews.

1.5.3 Sample
Non-probability sampling procedure was used in this research project. Thomson (2002) highlights that snowball sampling can be used in two ways and that there is usually a tension in terms of how it is defined from these two perspectives in different textbooks. In one way, snowball sampling may be presented in a sense that “a few identified members of a rare population are asked to identify other members of the population, those so identified are asked to identify others, and so, for the purpose of obtaining a non-probability sample or for constructing a frame from which to sample” (Thomson, 2002). Snowball sampling might also be presented in other texts in a way that “individuals in the sample are asked to identify other individuals, for a fixed number of stages, for the purpose of estimating the number of ‘mutual relationships’ or ‘social circles’ in the population” (Thomson, 2002).

With the first explanation borne in mind, snowball sampling was used in this research project to find traditional healers who happened to be known for having previously dealt with people who presented with symptoms of psychosis (*umuntu ophanjanelwa yikhanda noma uhlanya*) from those 2 Zululand areas. Initially, the researcher approached community members who happened to have knowledge of the whereabouts of a traditional healer in the area who has had an experience of helping people who had previously presented with symptoms of psychosis. In turn, the traditional healer was requested to provide information about how the researcher could liaise with caregivers of those they have healed to discuss the role of the
traditional medicine on the sufferer’s condition. This was done with great caution not to violate issues of confidentiality on the part of a traditional healer by requesting the consent of their clients first.

1.6 Procedures
The researcher visited traditional healers in their own work places and caregivers who were willing to participate in their home environments. The information acquired from participants was either audio-recorded or noted down.

1.7 Value of the Study
A psychologist comes into contact with clients from different cultural backgrounds. The information that was gathered from this research project might add to the body of knowledge in psychology that might be helpful to a new therapist like the researcher. This is particularly important because it is not about fitting clients from diverse cultural backgrounds into an already existing western psychological theory but also being cognisant of their cultural context and its dynamics (Corey, 2001). More importantly, the study might assist ‘African communities’ understand that psychosis might not be a treatable condition from a western point of view but it is manageable which might perhaps help decrease the number of people who wander aimlessly in the streets that seem to be presenting with symptoms of psychosis. The societies targeted might also gain insight about alternative ways of dealing with psychosis if its causes have been proven not to be associated with traditional factors.

1.8 Delimitation of the Study
Only 8 traditional healers from Esikhawini Township and Ongoye rural area were interviewed. The researcher cannot generalise with findings from only 8 participants that it is representative of every African Zulu speaking person’s attitude towards those suffering from psychosis. Yet again, 2 people in addition to traditional healers cannot be representative of the general population’s understanding of the condition. The method of sampling which is economical and easier to obtain participants (i.e. snowball sampling) that was used in this study has its own drawbacks which will put the researcher in a difficult position to make the research findings transferable from those specific contexts to others. Nevertheless, results gave a glimpse or indication of what lies within Zulu people’s perception towards those suffering from psychosis or the way they generally conceptualise the disorder and more importantly the role of their traditional medicine.
1.9 Ethical Considerations

The study and its aims were explained to all participants. Those who agreed to participate were asked to sign consent forms. The consent form was also explicitly explained to participants. Participants were requested to be audio-recorded as they shared their knowledge with the researcher. Those who felt uncomfortable with the idea of being audio-recorded, were asked to bear with the researcher to note down some of the important information they imparted during the interview. The researcher requested traditional healers to introduce the researcher to other participants who were caregivers of people who once visited the healers for the condition discussed. This was done only when those participants agreed to the traditional healers that they are willing to participate. The researcher did not meet those participants until they agreed to the traditional healer without feeling exposed. All participants were made aware of their right to decline at any moment during the interview should they feel uncomfortable.

1.10 Summary

In this chapter, the research project was introduced. The statement of the problem, aims and objectives, research methodology, value and limitations of this research project were presented. The next chapter will present the relevant literature that has been reviewed.
CHAPTER 2

LITERATURE REVIEW

2.1 Introduction

In this chapter, psychosis-related concepts from a few traditional South African perspectives, and how this condition is viewed in western societies with special reference to mainstream psychology and psychiatry are discussed. This will highlight how psychosis is conceptualised in certain South African cultural groups and how it is viewed in western societies. Research findings from various sources who investigated a similar phenomenon (i.e. psychosis) will be incorporated in this chapter. Mostly, the focus will be on the Zulu cultural group and its customs in order to offer a perspective on how this cultural group theorise, view and perceive psychosis with special reference to their traditional healers. Concepts of traditional medicine and traditional healing shall also be discussed separately.

Feldman (2006) defines psychology in simple terms as a study of human behaviour and mental processes. Psychology is a broad concept but for the sake of convenience and simplicity, this definition will be used in this study. There is no universal or clear-cut way of conceptualising human behaviour because humans are complex beings who are multidimensional in every sense of the word. Perhaps that is the reason why psychology offers more than 5 perspectives through which it conceptualises human behaviour including cognitive, humanistic, behavioural, socio-cultural and psychodynamic perspectives (Feldman, 2006). The fact that psychology has at least 5 perspectives through which it views human behaviour does not imply a lack of cohesion in the field (Feldman, 2006). It signifies rather the wider perspective that psychology takes in evaluating human behaviour.

Psychology from these perspectives is understood to be in search of objective knowledge (Hook et al., 2004). Hook et al. (2004) further state that in the pursuit to copy the natural sciences, psychologists have tried to construe their discipline as an objective, generalisable science. In addition, Hook et al. (2004) maintain that traditional western approaches to psychology are founded on certain presuppositions about humans and the world. These traditional western approaches fall under mainstream or commonly used ways of conceptualising human behaviour by psychologists. On the other hand, indigenous theoretical frameworks have been marginalised (Hook et al., 2004). This argument needs to be viewed
with caution as latest developments in the field of psychology seem to be slowly recognising the importance of the *systems* under which people live and are raised, concerning the phenomena of human behaviour and mental processes. For example, Bodies such as American Psychological Association and Psychological Society of South Africa (PSYSSA) are emphasising the importance of cultural sensitivity and competency skills needed by counsellors and psychologists when offering their services to mental health care users. Nevertheless, the researcher believes that Hook et al. (2004) had a point when they assert that mainstream psychology is mostly dominated by psychological theories that originated in western societies. Hook et al. (2004) maintain that the majority of those psychological theories are not value-free and indigenous theoretical frameworks are not as evenly represented as western originated theories in the field of psychology.

Furthermore, the focus on certain theoretical frameworks like Cognitive Behaviour Therapy (CBT) theory and psychoanalysis on the basis that they are “scientific” or evidence-based (i.e. because they have been intensely investigated) and the sidelining of indigenous modalities like transpersonal theories because of not meeting the “criteria” for scientific evidence is a phenomenon that needs more attention in the field of psychology. To support this premise, Menezes (2012) maintains that just because something is appealingly logical and rational does not imply that it brings us closer to the truth.

Even though the researcher supports the arguments that were put forward by Hook et al. (2004), the researcher nevertheless recognises that a growing number of psychologists from so called “western societies” write intensely about and recognise the importance of other dimensions of human functioning like spirituality when offering counselling and psychotherapy to mental health care users (e.g. Corey, 2001; Chang, Scott, & Decker, 2009). Hook et al. (2004) argue that the social sciences have substituted religion, mythology and other systems of knowledge in explaining the nature of being. “This has been accomplished by the claim to reveal the ‘truth’ through rationality and efficacious method” (Hook et al., 2004). Hook et al. (2004) maintain that psychological research, in particular, has been based on a construction derived from 19th century physical science. “In this model of science termed hypothetico-deductive science, theories are accepted or rejected based on empirical evidence” (Hook et al., 2004).
“The procedure carry on in the following way: Initially, a theory about human behaviour, relations, emotions, cognitions and so forth is formulated; secondly, hypotheses, in the form of statements or proposals, are derived from the theory; thirdly, concepts are plainly defined and operationalised in quantitative terms; fourthly, the hypotheses are tested practically; fifthly, when, in stage four, new facts or principles are discovered for which the supposed (hypothetical) component cannot account, the theory is attuned accordingly. The proponents of this model of science claim that in this logical and objective process we move closer to estimates of the truth” (Hook et al., 2004, p. 524).

Hook et al. (2004, p. 524) maintain, “in the past few decades, though, a number of questions that undermine the basic postulations of positivist social science have been posed. These include: Does a fundamental, knowable, unitary subject (person) exist? Are there universal psychological processes that can be revealed? Is there an objective external reality that can be measured and codified? Is research really progressive? Does spot on method provide a assurance of truth? Most importantly, in the context of their book, is the question whether social scientists can position their science as external to the workings of power relations and politics?”

It must be explicitly stated that Hook et al. (2004) did not use the concept politics in the sense of party politics but as daily practices in which specific understandings of the world, that is dominant discourses; come to be established as good or normal while others are relegated to the bad or abnormal. “Furthermore, is science ever objective or liberated from political import? Critical psychologists’ reply to this would be that knowledge-production is at all times already political. Denying this, or else taking political issues as irrelevant variables that need to be minimised in research for ‘objective’ truth, only masks the political nature of research. Without a doubt, it has been argued that research that is embedded in universalising apolitical ‘scientific’ terms, in many cases, acts as an important legitimating instrument for exclusionary or biased practices, as feminists have pointed out relating to ‘male stream’ research” (Hook et al., 2004, p. 524).

It is not the aim of this study to debate how political psychology is and therefore arguments in the above paragraphs may not be convincing enough due to limited space. The intention of bringing the above argument to the fore is to lay the ground for the following discussion on indigenous psychology as it is sidelined in mainstream psychology. The researcher has
included the above body of knowledge or work by Hook et al. (2004) to share the ideas of other psychologists who feel the same way about the status of indigenous theoretical frameworks in the field of mainstream psychology, which are predominantly western-originated theories.

There have been some adjustments and developments in social sciences or field of psychology in particular, that seem to address the issues posed by Hook et al. (2004). For example, qualitative research that seeks to tap into the phenomenological experiences or worldviews of research participants. This is not to suggest that qualitative research is more objective than quantitative research. Even qualitative research is not value-free, because in doing research on the experiential worlds of participants, how that information is collected and interpreted may be informed by certain already existing set of assumptions or preconceived ideas. In simple terms, how qualitative research is conducted is also not value-free just like its quantitative research counterpart.

Nevertheless, it must be understood that each of these research paradigms are relevant for certain contexts and phenomena being investigated. The above information serves as a background on indigenous belief systems and the role of traditional Zulu medicine in trying to deal with a condition like psychosis. The researcher argues that if psychologists are to become competent in a multicultural society like South Africa, they need to be equipped with rich knowledge of the various perspectives that people bring to counselling. Chang, Scott, and Decker (2004) report that the task of practitioners is to understand how their own beliefs about the way life is or should be, are often viewed as the “truth” rather than just one way of looking at a situation. More importantly, the researcher maintains that importing theories from other societies and using them in the counselling room or research environment with a client or research participant of another cultural origin respectively, without scepticism or any adjustments may be detrimental rather than constructive. Eells (2007) supports this view by mentioning that practitioners frequently misinterpret minority clients’ circumstances because they fail to notice these clients’ backgrounds, motivations, and state of affairs. Simultaneously, clinicians frequently fail to consider their own biases during the assessment process (Eells, 2007).
2.2 Zulu-Culture and Psychosis

The word Zulu means God’s people or persons of heaven (Washington, 2010). Intrinsic in the name is the real belief of the Zulu people that God is central and that they are divine (Washington, 2010). This alludes to the deep spiritual element that informs the Zulus’ perspective of what has been called mental health (Washington, 2010). According to the African Psychology Institution of the Association of Black Psychologists, African Psychology is ultimately concerned with understanding the systems of human Beingness, the features of human functioning, and the restoration of natural order to human development (Washington, 2010). It is worth noting that the commonly held misconception that Zulus praise ancestors (amadlozi) as their God is not true. Instead, ancestors act as mediators between Zulu people and the creator (uMvelinqangi) (Hook et al., 2004).

Washington (2010) uses the term African/Black psychology to refer to that area of psychology that is grounded in an African psychospiritual notion of being. Moreover, Washington (2010) maintains that, African/Black psychology holds that all sets are interconnected, that spirit infuse all living things, and that there is a component of the Divine within all things.

Washington (2010) explains the nomenclature that Zulus use to classify psycho-spiritual disorders. Washington (2010) uses the term psycho-spiritual disorders instead of mental disorders because of the way Zulu people conceptualise or view psychological problems. In Zulu culture illnesses in general are structured based on their causes (Washington, 2010). “One category of disease is umkhuhlane (illnesses of the natural cause). Incorporated under this category are isithuthwane (epilepsy), isifuba somoya (asthma) and ufuzo (familial/genetic disorders) such as isidalwa (mental retardation) and uhlanya (schizophrenia)” (Washington, 2010). The findings of Washington (2010) seem to suggest that Zulu people perceive ukuhlanya as an illness that has a genetic component. The researcher was under the impression that ukuhlanya (suffering from psychosis) is related to either not complying with the calling to become a traditional healer or to having been bewitched. To back up this view, Ellis (2011) maintains that Zulu people tend to regard mental illness such as madness (ukuhlanya) as stemming from bewitchment.
2.3 Another traditional South African perspective on conditions that present with “psychotic-like” symptoms

Niehaus, Oosthuizen, Lochner, Emsley, Jordaan,Mbanga, and Keyter (2004) conducted a research project on Xhosa speaking people in Western and Eastern Cape provinces of South Africa. The aim of their study was “to determine the extent to which amafufunyana and ukuthwasa were used as cultural explanatory models by traditional healers for Diagnostic and Statistical Manual of Mental Disorders’ (2000) (DSM-IV-TR) defined schizophrenia and whether there were significant phenomenological differences in schizophrenia symptoms in patients with the diagnosis of amafufunyana rather than ukuthwasa” (Niehaus et al., 2004). Niehaus et al. (2004) state that “ukuthwasa is viewed as a calling to serve the ancestors as a traditional healer, meaning that this is a special but normal event”. Nevertheless, while complying with this ‘divine calling’ confers special powers, refusing to accept this calling by the ancestors may lead to illness (called ukuphambana) (Niehaus et al., 2004). According to the limited understanding of the researcher, which is subject to correction, the concept of ukuphambana in Xhosa is equivalent to ukuphanjanelwa yikhanda or ukuhlanya in Zulu culture, which refers to a psychotic disorder.

Amafufunyana, conversely, was originally described as “a hysterical condition characterised by people speaking in an eccentric muffled voice in a language that cannot be understood, and strange and unexpected behaviour” (Niehaus et al., 2004). Niehaus et al. (2004) mention that the existing case descriptions, mostly of girls and young women, comprise of additional symptoms of undressing (tearing off clothes), violent behaviour and psychomotor agitation. “This condition is believed to be induced by sorcery that has led to possession by various spirits that may then speak through the individual in tongues” (Niehaus et al., 2004). Niehaus et al. (2004) further mentioned that amafufunyana was originally seen as a self-contained condition (lasting hours to days) without any comparable (equivalent) in western classification systems. Work that is more recent suggests that the descriptions of amafufunyana known by traditional healers do not have the “orderly unitary quality of the ritualised possession states presented in the literature” (Niehaus et al., 2004).

Niehaus et al. (2004) mentioned that the findings indicate that, in the group of Xhosa patients with schizophrenia, there were no symptoms that considerably differentiated between a diagnosis of ukuthwasa and amafufunyana. Alternatively, compared with patients with ukuthwasa or amafufunyana, patients with neither of these diagnoses were more probable to
live in a rural surrounding, to be married, and to have had specific stressors or substance abuse apparently predating psychotic symptoms (Niehaus et al., 2004). They further mentioned that in their sample of Xhosa patients, around half of those with a past of schizophrenia were diagnosed with amafulunyana or ukuthwasa by the traditional healer (Niehaus et al., 2004). No differences in the central symptoms of schizophrenia were observed which could clarify why some psychotic symptoms are perceived as ‘good’ (ukuthwasa) and others as an illness requiring treatment (amafulunyana) (Niehaus et al., 2004).

Niehaus et al. (2004) further discovered that “subjects with a family history of either schizophrenia or other psychiatric disorders were more probable to receive the diagnosis of ukuthwasa rather than amafulunyana, signifying that psychotic symptoms are more likely to be viewed as abilities or giftedness passed on from one generation to the next in the case of ukuthwasa, but as an sickness in the sporadic cases (amafulunyana)”. Niehaus et al. (2004) further warn clinicians that it is important to realise that ukuthwasa, even though viewed as a potentially positive occurrence, may herald the commencement of schizophrenia. Debatably, individuals with a family history of psychotic symptoms, even if these are not associated with impairment (amafulunyana), may be at higher risk for the development of psychological disorders (Niehaus et al., 2004).

Furthermore, they mentioned that even though ukuthwasa is not regarded as an illness in the Xhosa culture, their findings suggest that, in at least a subgroup of participants, ukuthwasa is relatively impossible to tell apart from amafulunyana in terms of the core symptoms of schizophrenia, including impairment (Niehaus et al., 2004). Rural married subjects with identifiable stressors were less likely to be diagnosed with amafulunyana or ukuthwasa (Niehaus et al., 2004). This may imply that these terms are less likely to be utilised in patients with higher premorbid functioning such as married subjects and where other, more apparent explanations can be given (Niehaus et al., 2004).

They further warned that the data they gathered do not essentially mean that all individuals with amafulunyana or ukuthwasa suffer from schizophrenia; rather they indicate that amafulunyana and ukuthwasa might be used as explanatory models in a division of schizophrenia sufferers (Niehaus et al., 2004). Their assumption on this phenomenon is that it could be that families or traditional healers prefer a term such as amafulunyana to describe
mental illness or psychological distress in general, since this term is possibly associated with fewer stigmas than a diagnosis of schizophrenia (Niehaus et al., 2004).

The researcher believes that Niehaus et al. (2004) offer a valid assumption but from a different perspective from traditional healers. As an alternative, the researcher assumes that traditional healers might be using the concept of amafufunyana more often for people who present with “psychotic-like” symptoms because this concept has a spiritual element in it and this is how Africans tend to view psychological problems. In support of this view, Kangwa and Catron (2010) report that disease has a spiritual cause for Zulu people. The term “schizophrenia” on the other hand, as defined by American Psychiatric Association (2000) presents this condition as “mental dysfunction” which is a worldview commonly adopted by westerners.

2.4 The Concept of a Traditional Healer

Moagi (2009) states that “by definition a traditional healer in the South African context is someone who possesses the gifts of receiving spiritual guidance from the ancestral world”. Moagi (2009) maintains that traditional healers still play an important role in assisting people who present with either mental or physical health problems in Africa in general and South Africa in particular.

Skuse (2007, p. 80) discusses traditional healing in the African context. Skuse (2007) argues that traditional healers are a significant source of psychiatric support in many parts of the world, including Africa. “Traditional healers offer a parallel system of belief to conventional medicine regarding the origins, and hence the proper treatment of, mental health problems” (Skuse, 2007). Skuse (2007) reveals that in three regions of Africa including South Africa, traditional healers were still more important than psychiatrists trained in western medicine. Skuse (2007, p. 80) describes how some years ago, it was estimated that there were nearly 10 times as many traditional healers practising in South Africa as there were doctors trained in modern medicine.

“The prevailing justification for their interventions, according to traditional beliefs, is that illness or disease is a supernatural phenomenon” (Skuse, 2007). A hierarchy of vital powers governs its manifestations (Skuse, 2007). “At the top of this hierarchy is a deity of greatest power, followed by lesser spiritual entities, ancestral spirits, living people, animals, plants and then objects” (Skuse, 2007). “These entities interrelate and, should they become
disharmonious, illness could ensue. Harmony can, though, be restored through judicious intervention, provided by a well-trained person who treats the patient holistically, within the context of his/her family and community” (Skuse, 2007).

Skuse (2007) explains that indigenous healers may be regarded as falling into three broad categories: diviners, most of whom are female and chosen by their ancestors to this calling; herbalists; and faith or spiritual healers, more often than not within the Christian tradition. Lumsden-Cook, Thwala, and Edwards (2006) support the notion that native South Africans tend to use traditional healing services more often than western medicine. Lumsden-Cook, Thwala, and Edwards (2006) asserted that for a lot of the indigenous people of South Africa, sickness or emotional crisis precipitates a visit to a traditional healer.

Thwala and Edwards (2010) give a clear picture of the structure or service provision of the health care system in South Africa. They mention that, currently, there are just about 6,000 psychologists, 10,000 social workers, 30,000 medical doctors and 125,000 nurses to care for nearly 50 million people in South Africa (Thwala, & Edwards, 2010). Effectively, this means that other community helping resources do the bulk of the work, particularly some 300,000 traditional healers and more than one million African Indigenous Church (AIC) faith healers whose healing is fundamentally spiritual in nature (Thwala, & Edwards, 2010). This gives a clear indication that most native South Africans still rely more on traditional healers for their well-being than western orientated health care providers (Thwala, & Edwards, 2010).

There have nevertheless been some changes in the health care system in South Africa. Van Ransburg (2009) explains how traditional African health practice has in recent times been mainstreamed in South Africa by the promulgation of the Traditional Health Practitioners Act, No. 35 of 2004. This Act has fundamental importance in the mental health care scenario with its stress on mental health in the definition of traditional health practice, namely: “(a) the performance of a function, activity, process or service that includes the utilisation of a traditional medicine or health practice or function; (b) to diagnose, treat and prevent physical or mental illness; (c) to rehabilitate a person to resume normal functions and (d) to physically and mentally prepare a person for phase of life changes (puberty, adulthood, pregnancy, childbirth and death)”. “The purpose of the Traditional Health Practitioners Act, No. 35 of 2004 is to: - establish the Interim Traditional Healers Council of South Africa (as detailed in
Chapter 2 of this Act); - provide for the registration, training and practice of traditional healers (Chapter 3); - serve and protect the interest of the public who use the services of traditional health practitioners (Chapters 4 and 5 of the Act)” (van Ransburg, 2009, p. 157).

Melato (2000) explores traditional healers’ views on the South African government’s proposal of integrating traditional healing into the legally recognised national health system. The findings of this study indicate that “the world view in which traditional healing practices are entrenched, has a lot of influence on future relations with western practitioners” (Melato, 2000). Melato (2000) states that “this traditional African worldview informed by cultural relativism, sees illness and health as well as ancestors and God as interconnected and existing in a state of balance. Based on this view, healing must be approached from the worldview of the patient and that of his or her cultural group”.

According to the results of this study, traditional healers perceive themselves as equal to western practitioners because of their training and ability to heal a variety of illnesses (Melato, 2000). They see their role as that of providing alternative healing through being a medium between people and ancestors and their unique gift to heal spiritual illnesses (Melato, 2000). Moreover, Melato (2000) found that traditional healers perceived integration as a source of unity and recognition and although challenges such as disunity among traditional healers themselves as well as fears of oppression and subordination from their western counterparts were identified, this process is looked upon as a positive and necessary step by traditional healers. Education and negotiation were acknowledged as potential solutions to the above-mentioned obstacles and a way forward towards integration (Melato, 2000). In spite of this positive attitude, Melato (2000) states that participants emphasised that they would prefer collaboration to total integration with the western practitioners. The reason for this preference is linked to the healers’ understanding and treatment of illness (Melato, 2000). This is based on the African worldview, which varies significantly from the modern view of disease (Melato, 2000).

Melato (2000) explains that the findings of this study show that there is still a mindset of mistrust and suspicion about western-trained professionals from traditional healers. “The general impression is that by working in the same environment with westerners, the traditional healing system could lead to possible extinction” (Melato, 2000). Of the two
systems, working side-by-side seems to be the only form of integration, which could profit all the citizens of the country (Melato, 2000).

2.4.1 Different Types of Traditional Healers

Truter (2007) discuss different categories of traditional healers in South Africa. Truter (2007) state that traditional healers do not all perform the same functions, nor do they all fall into the one category. Each healer has their own field of expertise or methods of diagnosis and their own particular medicine (Truter, 2007). According to Truter (2007), different types of African traditional healers can be identified as discussed in this section. Even though each type has its distinctive features, their roles do overlap significantly (Truter, 2007).

The following discussion on different types of traditional healers was extracted directly from Truter (2007).

2.4.1.1 Isangoma (diviner)

A _sangoma_ or diviner is the most senior of the traditional healers. She is someone who defines an illness or disease (diagnostician) and in addition divines the state of affairs of the illness in the cultural context. More often than not, diviners (about 90% of cases) are female, even though the calling is open to people of any gender, age or status. They are usually highly valued in their community for their guidance and mystical powers. Diviners are identified by different names in the different South African cultures. For instance, _amaggira_ in Xhosa, _ngaka_ in Northern Sotho, _mungome_ in Venda, and _selaoli_ in Southern Sotho and Tsonga. The majority of South Africans, however, generally refer to them as _sangomas_, which is from the Zulu word _izangoma_. _Isangoma_ (diviner) may or may not have knowledge of herbal medicines. A diviner’s speciality is divination where she works within a traditional religious supernatural context and acts as an intermediate with the ancestral spirits. _Izangoma_ focus on diagnosing the unexplainable. _Izangoma_ trace the causes of specific events and interpret the messages of the ancestors. Whilst the focus is on divination, they frequently also give medication for the specific case they have diagnosed.

Preparation to turn out to be a _sangoma_ is not a personal option but is a calling bestowed by ancestors to a person who then is apprenticed to a qualified diviner for more than a few months. During this period, the diviner learns to throw the bones and to control the trance-
like states where communication with the ancestral spirits takes place. On completion of preparation, the diviner undergoes the *ukuthwasa* process, which is a culturally accepted form of ancestral spirit possession when the diviner is called by ancestors to become a diviner. There is no set training period; it might take anything from 6 months to 10 years, given that qualification depends on 2 factors. Firstly, the teaching diviner only qualifies a learning diviner once a final fee is paid. Secondly, the diviner retains territorial exclusivity where the pupil pays allegiance to the teacher. Secondly, Truter (2007) discuss *Izinyaga*.

### 2.4.1.2 Inyanga (traditional doctor herbalist)

An *inyanga*, referred to as *inyanga* in Zulu, *mganga* in Swahili and *ixhwele* in Xhosa specialises in the use of herbal and other forms of medicinal preparations for treating illnesses. *Izinyanga* (plural for *inyanga*) possess wide-ranging knowledge of curative herbs, natural treatments and medicinal mixtures of animal origin. *Inyanga* does not receive a calling, and select to become an *inyanga*. About 90% of *izinyanga* are male. Their wide-ranging curative expertise comprises of preventive and prophylactic treatments, rituals and symbolism as well as preparation for fortune and fidelity. Some of *izinyanga* treat only one specific condition and become well-known experts on that disease. These include rainmakers and specialists in conditions of specific organs such as heart, kidney or lung disease consultants. *Izinyanga* in general, spend only some years as an apprentice and do not profess to have divine powers. This leads to patients having to practically visit the *izinyanga* and have a case history taken. This contrasts how *izangoma* do their work, where the sick person does not have to be present. *Izinyanga* run their business through referrals and regularly have storage places where herbs and remedies are sold. Thirdly, Truter (2007) discuss *Abathandazi*.

### 2.4.1.3 Umthandazi or umprofithi (faith healer or prophet)

A faith healer which is referred to as *umthandazi* in Nguni, and *muProfithi* in Sotho is more often than not a professed Christian who belongs to either mission or African independent churches. Faith healers heal typically through prayer, laying hands on patients, or proving ash and holy water. Faith healers believe that their healing power comes from the Almighty via ecstatic states and trance-contact with a spirit which is called *uMoya*, or occasionally a combination of both Christian Holy Spirit and spirit of ancestors. Faith healers utilise a combination of herbs, remedies and holy water in their healing approach. Faith healers’
healing system is moulded on the *sangoma* group pattern whereby the afflicted live for months and in other instances years at the prophet’s residence.

Faith healers’ period of training is not prearranged since the ‘student’ is prayed for, goes through purification rites, and is in close contact with the healer. Faith healing is sometimes favored because the doctrines used seem to integrate both Christian and African traditional beliefs. Faith healers understand sickness in terms of the patient’s world view and perception. The dynamic displays of emotions in rhythmic movements and dances which are regular practice in faith healing follow the same model of the ceremonial dances of *izangoma*. Fourthly, Truter (2007) discusses traditional midwives.

### 2.4.1.4 Traditional midwife/Birth Attendant

Traditional birth attendants which are referred to as *ababelethisi* are usually elderly women who have been midwives for numerous years and are highly valued for their obstetric and service expertise. Traditional midwives center their attention on pregnancy problems and aid pregnant women at the time of delivering. They are in charge of responsibilities such as the teaching of behavioural avoidance among pregnant women, ritual bathing of the mother, ritual removal of the placentas, provision of healing medicine and customary massage after delivery. These practitioners also provide advice on postpartum and cord care and give support for breastfeeding as well as counsel on marital issues, contraception and fertility.

*Izinyanga* or diviners act as consultants in case a difficult labour or if complications occur. Women who seek to become traditional birth attendants should meet a specific criteria. For instance, they must have had at least two children in order to able to appreciate the joys and pains of bearing a child. Training involves 15 to 20 years of apprenticeship prior to assuming the position. Traditional birth attendants do not charge for their services but contributions in the form of gifts are usually provided. These practitioners may also be invited to be guests of honour when the child is named. There are also other types of traditional healers, such as traditional surgeons who are referred to as *ingeibi* who perform circumcision as art of an African cultural initiation ceremony. Next, the researcher looks at a concept of traditional medicine.
2.5 Traditional Medicine

In the South Africa’s Traditional Health Practitioner’s Act No. 35 of 2004, Traditional medicine is defined as “an object or substance used in traditional health practice for the diagnosis, treatment or prevention of a physical or mental illness; or any curative or therapeutic purpose, including the maintenance or restoration of physical or mental health or well-being in human beings, but does not include a dependence-producing or dangerous substance or drug”. Richter (2003) recognises that the World Health Organisation (WHO) finds it a challenge to give one clear-cut definition to the broad range of characteristics and elements involved in the concept of traditional medicine. However, for the sake of convenience they state that “it includes diverse health practices, approaches, knowledge and beliefs incorporating plant, animal and/or mineral based medicines, spiritual therapies, manual techniques and exercises applied singularly or in combination to maintain well-being, as well as to treat, diagnose or prevent illness” (Richter, 2003).

One of the definitions given for African Traditional Medicine by the WHO is that “it is the sum total of all knowledge and practices, whether explicable or not, used in diagnosis, prevention and elimination of physical, mental, or societal imbalance, and relying exclusively on practical experience and observation handed down from generation to generation, whether verbally or in writing” (cited from Richter, 2003).

2.6 Psychosis from a Western Theoretical Framework (Psychology and Psychiatry Point of View)

Psychosis, broadly, indicates impairment in reality-testing ability (Stern, Rosenbaum, Fava, Biederman, & Rauch, 2008, p. 371). Feldman (2006) defines psychosis more simply, as “a class of disorders where distortion of reality occurs” (p. 538). American Psychiatric Association (2000) describes this condition by tracing it back to how it was initially defined: “The concept psychotic has historically received a number of different definitions, not any of which has achieved universal acceptance. The narrowest definition of psychotic is restricted to delusions or prominent hallucinations, with the hallucinations occurring in the absence of insight into their pathological nature. A somewhat less restrictive definition would involve prominent hallucinations that the individual realises are hallucinatory experiences. A broader definition includes other positive symptoms of schizophrenia such as disorganised speech, grossly disorganised or catatonic behaviour. Unlike definitions based on symptoms, the
definition used in earlier classifications such as DSM-IV and ICD-9 was almost certainly far too inclusive and focused on the severity of functional impairment”.

American Psychiatric Association (2000) further maintain that “in that context, a mental disorder was termed ‘psychotic’ if it resulted in ‘impairment that grossly interferes with the capacity to meet ordinary demands of life’. The concept has also formerly been defined as a ‘loss of ego boundaries’ or a ‘gross impairment in reality testing’. In DSM-IV-TR, the concept psychotic refers to the presence of specific symptoms. However, the specific group of symptoms to which the term refers varies to some extent across the diagnostic categories. “In schizophrenia, schizophreniform disorder, schizoaffective disorder, and brief psychotic disorder, the term psychotic refers to delusions, any prominent hallucinations, disorganised speech, or disorganised or catatonic behaviour. In psychotic disorder due to a general medical condition and in substance-induced psychotic disorder, psychotic refers to delusions or only those hallucinations that are not accompanied by insight. Finally, in delusional disorder and shared psychotic disorder, psychotic is equivalent to delusional” (American Psychiatric Association, 2000, p. 297-298). This description of psychosis offered an overview of how this condition was initially described in previous editions of Diagnostic and Statistical Manual of mental disorders-IV-Text Revision (DSM-IV-TR) and how its is currently conceptualised in the current edition.

Psychologists believe that schizophrenia, one of the psychotic disorders; usually follow a certain pattern or phases. Halgin and Whitbourne (2007, p. 279) state that the diagnosis of schizophrenia is a marked disturbance lasting for at least 6 months. “During this 6-month period is an active phase of symptoms, such as delusions and hallucinations or disorganised speech, disturbed behaviour, and negative symptoms like speechlessness or lack of initiative” (Halgin, & Whitbourne, 2007).

According to Halgin and Whitbourne (2007), the active phase more often than not does not appear without warning signs. Most, but not all, cases have a prodromal phase, a period prior to the active phase during which the individual shows progressive deterioration in social and interpersonal functioning (Halgin, & Whitbourne, 2007). “This phase is marked by several maladaptive behaviours, such as social withdrawal, inability to work productively, eccentricity, poor grooming, inappropriate emotionality, peculiar thought and speech, unusual
beliefs, odd perceptual experiences, and decreased energy and initiative” (Halgin, & Whitbourne, 2007). For most people, the active phase is followed by a residual phase, in which there are continuing suggestions of disturbance similar to the behaviours of the prodromal phase (Halgin, & Whitbourne, 2007, p. 279).

“In studying young people at risk for developing schizophrenia, researchers have indentified what they call the CASIS cluster, comprised of cognitive deficits (C), affective disturbances (A), social isolation (SI), and school failure (S)” (Halgin, & Whitbourne, 2007, p. 279). Halgin and Whitbourne (2007, p. 279) maintain that “in addition to the CASIS cluster, researchers have documented other early signs of impending deterioration known as positive symptoms, exaggerations or distortions of normal thoughts, emotions and behaviour. Positive symptoms are viewed as direct lead-ins to the full expression of psychosis” (Halgin, & Whitbourne, 2007, p. 279).

Carson, Butcher and Mineka (1996) mentioned that psychiatrists usually argue for the dopamine hypothesis. According to the dopamine hypothesis, schizophrenia is the result of an excess of dopamine activity at certain synaptic sites (Carson, Butcher, & Mineka, 1996). Variants of this idea include hypotheses that a person with schizophrenia has too many postsynaptic dopamine receptors or that these receptors have for some reason become supersensitive (Carson, Butcher, & Mineka, 1996). In recent years, however, the dopamine hypothesis has proved inadequate as a general formulation of aetiology (Carson, Butcher, & Mineka, 1996). It is also interesting to look at some classical psychological explanations of schizophrenia some of which are outdated and some are recent.

2.6.1 Classic Psychoanalytic view of Schizophrenia

The following discussion was extracted directly from Sammons (2001). Sammons (2001) discusses the classical Freudian psychoanalytic perspective on psychosis as follows.

“The psychoanalytic approach sees schizophrenia as the product of the disintegration of the ego. It is the ego’s function to keep control of the id’s impulses and strike a compromise between the demands of the id and the moral boundaries of the superego. Based on Freudian theory, some types of abnormal rearing (particularly if there is a cold, rejecting mother) can result in a frail and fragile ego whose ability to contain the id’s desires is limited. This can lead to the ego being ‘broken apart’ by its effort to contain the id, leaving the id in overall control of the psyche.
If this takes place, the person loses contact with reality as he/she can no longer tell between him-/herself and others, his/her desires and fantasies and reality (one need an ego to be able to do this). They regress to a state of ‘primary narcissism’ slightly different from that of a newborn infant, subject to his/her animal instincts, incapable of organising his/her own behaviour and hallucinating as a result of their basic inability to distinguish between his/her imaginations and reality.

The classic psychoanalytic view is not highly regarded any more, for several reasons. The development of effective antipsychotic medication in the 1950s and 1960s gave the biological view of schizophrenia a boost from which the psychological theories have never really recovered. As mainstream psychology turned away from Freud’s tripartite model (id, ego and superego) of the psyche due to the influence first of behaviourism and then of the cognitivists, psychoanalytic theories generally fell out of favour. Research findings showed that the caregiver's personality was not a steady predictor of mental illness and the ‘schizogenic’ mother approach came to be considered as an embarrassing, sexist holdover from a less enlightened period. Nevertheless, much research carries on to implicate a disturbed upbringing as a risk in schizophrenia onset and relapse. Finally, the apparent failure of psychodynamic therapies to fruitfully treat psychotic patients led to the abandonment of this approach by the most committed psychoanalysts” (Sammons, 2001).

It must be stated that there are many theories that fall within the psychodynamic approach to psychosis. Theorists such as Melanie Klein, Donald Winnicott, and Carl Jung to name a few; each have their own theoretical assumptions about the nature of and psychic mechanisms underlying what is referred to as psychosis (Mace, & Margison, 1997). Theories proposed by each of these analysts will not be discussed in detail in this study. Relatively recent writings on psychosis from a psychodynamic point of view tend to put less emphasis on the mother-infant relationship as the core causal factor of psychosis (Mace, & Margison, 1997). Alanen (cited in Mace, & Margison, 1997) stress that susceptibility to schizophrenia also depends on contributions from ongoing interactional psychopathology within the family. Primitive defence mechanisms, predominantly projective identification, commonly operate in the families of schizophrenic patients (Mace, & Margison, 1997). The effects of abnormal parental personality on the vulnerable child persist throughout development while the persisting symbiotic needs of the vulnerable continue to distort relations within the family (Mace, & Margison, 1997).
Other recent theoretical frameworks also have important practical consequences. Biener (cited in Mace, & Margison, 1997) discusses the distortion of reality in the psychotic patient and links this with the concept of betrayal. He argues that all neurotic and psychotic patients have suffered from experiences of betrayal (Mace, & Margison, 1997). “Psychotic patients have been betrayed so severely that they feel there is no one left to trust in the world” (Mace, & Margison, 1997). He maintains that trust between therapist and patient must be built on reality, and ego mechanisms that seek to distort reality must be challenged (Mace, & Margison, 1997). McWilliams (2011, p. 74) maintains, “probably the most important thing to understand with psychotic illness or psychotic level psychologies is that they are terrified”. McWilliams (2011) added that “adopting any approach that permits a lot of ambiguity, as does traditional analytic therapy with neurotics, is like throwing gasoline into a flame of psychotic-level terror”. Giovacchini (cited in Mace, & Margison, 1997), similarly, confirm that the private, inner reality constructed by the schizophrenic patient acts as a barrier to empathy and a threat to the analyst.

2.6.2 Relatively Recent General Discussion of Psychosis

The following discussion was extracted directly from British Psychological Society (2000). British Psychological Society (2000) discusses psychosis in general terms as follows.

“Generally, proposed causes of psychotic experiences have been divided into factors within the psychological make-up of the individual, social and environmental factors, and biological factors. All of these factors are significant, and interact with one another. Since there is a very close relationship between the mind and brain, it not easy to draw clear lines between biological factors and psychological factors. Biological and psychological causes of psychotic experiences can be relatively important for different people. Still, when we know more, the nature and causes of psychotic experiences will remain complex and has multiple factors. Occasionally psychotic experiences can be elicited by something relatively minor, but are maintained by some kind of vicious circle, concerning the person’s situation or their reaction to the experience.

Generally, the vast range of possible or proposed causes of psychotic experiences has been divided into broad categories. Many people will have heard of the ‘nature-nurture’ contest. This refers to the consideration of the relative contributions made by genetic or biological factors as opposed to upbringing and experience on human behaviour. Certainly, this debate
also occurs with respect to the causes of psychotic experiences. Factors within the psychological make-up of the individual, social and environmental factors, and biological factors are all likely to play roles in the development of such experiences. Of course, all of these factors are important; all three of these broad classes of possible causes of psychotic experiences (psychological, social and biological) are imperative and interact with each other.

There is no convincing research that proposes that schizophrenia develops solely as the result of psychological phenomena, such as life experiences, developmental difficulties, interpersonal problems, emotional conflicts. Psychologists are increasingly accepting that schizophrenia is determined by complex interaction of genetics, altered brain functioning, and environmental processes, all of which serve to cause changes in cognitive functioning and behaviour. Based on the stress-diathesis model, individuals may inherit a vulnerability to schizophrenia, which is expressed when the individual is exposed to stressors from the environment” (British Psychological Society, 2000).

2.7 Summary

In this chapter, already existing literature related to this research project was discussed. The discussion of literature was introduced by first looking at the status of indigenous psychology within the broader field of psychology. The researcher argued that indigenous theoretical frameworks are subordinated by theories that originated in western societies. The commonly used theories in psychological literature and practice were referred to as “mainstream psychology”. Psychosis, traditional healing and medicine from a South African point of view with special reference to the Zulu culture were also discussed. The discussion was ended by looking at psychosis from a western point of view with special reference to psychology and psychiatry. The next chapter will delve on the research methodology of this research project.
CHAPTER 3

RESEARCH METHODOLOGY

3.1 Introduction
In this chapter the research methodology used is described. The design of this research project, how information was gathered, the sample that was targeted, as well as the means through which the data were analysed is discussed.

3.2 Research Design
A qualitative approach was followed. Welman, Kruger, and Mitchell (2005, p. 188) mention that “theoretically speaking, qualitative research can be described as an approach rather than a particular design or set of techniques”. Welman, Kruger, and Mitchell (2005) maintain that it covers an array of interpretive techniques which seek to describe, decode, translate, and otherwise come to terms with the meaning of naturally occurring phenomenon in the social world. Because the researcher was interested in studying traditional healers’ and caregivers’ views on the role of traditional Zulu-medicine on psychosis, the researcher felt that qualitative research design was more suitable.

Welman, Kruger, and Mitchell (2005, p. 188) maintain that qualitative research design can be used successfully in description of groups, (small) communities, and organisations. This statement encompasses what the researcher intended to investigate. On the other hand, quantitative methods may be more useful in hypothesis-testing research which is not the intention of this research project.

3.3 Research Sample
Non-probability sampling procedure was used in this research project. In some communities, especially those in developing countries, the only feasible way to find its members is by asking other members (Welman, Kruger & Mitchell, 2005). Snowball sampling was used to find traditional healers from Esikhawini and Ongoye areas who were known for having previously dealt with a person who presented with symptoms of psychosis (uhlanya). Four traditional healers from Esikhawini as well as 4 other traditional healers from Ongoye participated in the study. In addition, a caregiver from each of these places for a person who
once presented with symptoms of what is termed “psychosis” in western societies was also included in the study. Ten participants participated in this research project.

The traditional healers who participated in the study directed the researcher to the caregivers of those who once presented with symptoms of psychosis. Initially, the researcher randomly approached community members from each section of Esikhawini Township and Ongoye area who happened to have knowledge about where the researcher could find a traditional healer in the area who had an experience of helping those who had previously presented with symptoms of psychosis. During the encounters with traditional healers, the researcher requested information of the whereabouts of caregivers of those they have healed to discuss the effects of the traditional medicine on the sufferers’ condition. This was done with great caution not to violate issues of confidentiality on the part of a traditional healer by asking the healer to request the consent of their clients first.

### 3.3.1 The Sampling Criteria

Participants were selected according to specific criteria. The criteria for healers were:

- To be known as traditional healers in the area
- To be mentally sound enough to consent to participate in the study
- To be willing to participate
- To be Zulu-speaking and belonging to the Zulu clan

Criteria for caregivers of those who had visited the traditional healers:

- To be mentally sound enough to consent to participate in the study
- To be willing to participate
- be 16 years or older
- obtain the consent of parents/guardians to participate if they are less than 18 years of age
3.4 Research Setting

The study was conducted in the traditional healers’ working environments. The researcher was seated as if he was one of the traditional healers’ clients and started the conversation (interview). Similarly, after having been helped by the traditional healers to liaise with caregivers of their previous clients who once presented with symptoms of psychosis, the researcher visited them in their home environments. Conducting interviews in this way helped the researcher enjoy both the benefits of unstructured interviews as well as natural experimental kind of a research. The benefit of the latter type of research is that, if participants are in their normal environments their behaviour is likely to be natural and representative of what they do on an everyday basis (Feldman, 2006).

3.5 Data Collection

3.5.1 Data Collection Instrument

An interview was chosen as a data collection instrument. Specifically, unstructured in-depth interviews were selected as a means for collecting data for this research project. Welman, Kruger, and Mitchell (2005, p. 198) mention that, in unstructured interviews, the interviewer simply suggests the general theme of discussion and poses further questions as these come up in the spontaneous development of the interaction between the interviewer and research participant. The interviewer’s question should thus be directed at the participant’s experiences, feelings, beliefs, and convictions about the theme in question (Welman, Kruger, & Mitchell, 2005). Welman, Kruger, and Mitchell (2005) further maintain that interviewers should be extremely careful not to suggest certain responses in the way in which they phrase their questions such as, for example by asking leading questions (except when the researcher looks for underlying or hidden attitudes). Previously compiled questions such as those that suggest a particular theoretical point of view should be restricted to a minimum if not avoided altogether (Welman, Kruger, & Mitchell, 2005).

Similarly, in this research project a theme was chosen which was the traditional healers’ and caregivers’ views on the role of traditional Zulu-medicine on psychosis. Further questions related to this theme were asked based on the participants’ responses. This means that the researcher encouraged participants to elaborate on issues related to this theme as they emerged during interviews.
The main research questions were:

- What are your views on the role of traditional Zulu-medicine on psychosis? (directed to healers)

- What are your views on the impact and role of traditional Zulu-medicine on your relative’s condition of psychosis? (directed to caregivers).

Further questions were based on the participants’ initial responses.

3.6 Data Analysis

After the data were collected, data were organised and analysed. Content analysis refers to the gathering and analysis of textual content (Struwig, & Stead, 2007). For the analysis of open-ended questions of unstructured interviews, qualitative content analysis was performed. Notes and transcripts were prepared and themes were identified.

3.7 Ethical Considerations

The aims of the study were explained to participants who agreed to participate, who were then asked to sign a consent form. The content of and reason for the consent form was carefully explained. Participants were requested to be audio-recorded. Participants who felt uncomfortable with being recorded were explained the importance of recording important information that came out of the interviews. The participants were assured of their right to privacy and were informed that their identities remain anonymous (Welman, Kruger, & Mitchell, 2005, p. 201). Nevertheless, the decision of some participants not to be audio-recorded was respected.

Participants were also assured that they would not suffer any physical or emotional harm. It was mentioned previously that the researcher requested the traditional healers to introduce the researcher to other prospective participants who were caregivers of clients the healer saw for the condition discussed (psychosis). The researcher only interviewed those participants who informed the traditional healer that they were willing to participate in the study. All participants were made aware of their right to decline to participate at any moment during the interview when they felt uncomfortable with the process.
3.8 Reflexivity
The results of this study which were analysed by using content analysis (transcriptions and themes) might have been inevitably influenced by the researcher’s personal lived experiences, biases and presumptions. This is especially true because the researcher belongs to the same cultural group or community that was interviewed. The focus of this study on unstructured interviews was aimed at reducing the odds of preconceived ideas of the researcher to influence both the way data was collected and interpreted. These unstructured interviews were a reflection of the flexibility of the approach and its ability to interact with the data that was presented by the interviewees. Nevertheless, the discussion of the results on chapter 5 is open to reinterpretation, since it reflects the researcher’s own interpretations against the already existing literature. The discussion on chapter 5 is laid down against the already existing literature in order to refute or confirm the results of this study presented in chapter 4. Chapter 4 attempts to present the data as it was presented by the participants without any views on the part of the researcher.

3.9 Summary
The researcher used qualitative research design. The researcher conducted unstructured interviews that were predominantly open-ended. However, depending on the participants’ responses, specific questions were also asked as a way of probing participants to elaborate on certain responses. The data was collected from a sample of 10 participants from the Esikhawini and Ongoye areas in KwaZulu-Natal. The sample consisted of 8 traditional healers and 2 caregivers of people who once presented with psychotic symptoms. Consent was obtained from participants themselves. Anonymity and confidentiality were ensured during the interviews as well as reports. The following chapter will present the results of this research project.
CHAPTER 4

RESULTS

4.1 Introduction

4.1.1 Characteristic of Respondents/Participants

Participants of the study included 4 traditional healers from KwaDlangezwa, 3 males and 1 female. Among the 3 male healers there were 2 herbalists (*izinyanga*) and a faith healer who uses both *amakhabi* and holy water to heal. The female healer was a diviner (*izangoma*). Four healers from Esikhawini also participated in the study. This group consisted of 3 male healers and 1 female healer. Among the 3 male healers there were two herbalists (*izinyanga*) and a diviner (*isangoma*). The female healer referred to herself as a diviner who is also called *umkhokheli* (another Zulu word for a female-faith healer who also prophecies).

In addition to healers, participants included 2 caregivers of people who once presented with symptoms of *ukuhlanya*. All who were approached agreed to take part in the study. However, most of them reported that they were no able to sign the consent form because they were illiterate. Most participants initially expressed discomfort with the idea of being audio-recorded but, after having been assured about their anonymity most of them agreed. However, the two caregivers as well as one traditional healer stated that they did not mind giving the researcher the information that he required so long as it was not audio-recorded. This request was respected by the researcher. Details of participants who took part in the study are presented in a table below.
<table>
<thead>
<tr>
<th>Category</th>
<th>Gender</th>
<th>Place</th>
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</thead>
<tbody>
<tr>
<td>Participant 1 (herbalist)</td>
<td>Male</td>
<td>Esikhawini</td>
</tr>
<tr>
<td>Participant 2 (herbalist)</td>
<td>Male</td>
<td>Esikhawini</td>
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<tr>
<td>Participant 3 (faith healer)</td>
<td>Male</td>
<td>Esikhawini</td>
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<tr>
<td>Participant 4 (diviner)</td>
<td>Female</td>
<td>Esikhawini</td>
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<tr>
<td>Participant 5 (diviner/faith healer)</td>
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<td>KwaDlangezwa</td>
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<td>Participant 7 (diviner)</td>
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<td>Participant 8 (herbalist)</td>
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<td>Female</td>
<td>Esikhawini</td>
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<tr>
<td>Participant 10 (caregiver)</td>
<td>Female</td>
<td>KwaDlangezwa</td>
</tr>
</tbody>
</table>

4.1.2 Preview of the Chapter

This chapter will present the analysis of the results, which led to an identification of 4 main themes. The first theme concerned the function of traditional Zulu-medicine in treating *ukuhlanya* (a Zulu word for insanity, madness or psychosis). Before proceeding with the themes, it is important to clarify a few points. In this study, the word *ukuhlanya* and psychosis are used interchangeably as having the same meaning. Nevertheless, the researcher is aware that there could be subtle different meanings for these words, which may be due to different cultural worldviews where they originated. For instance, Zulu people tend not to use the classification system that is used by western mental health care practitioners to classify
psychosis into different categories based on symptom presentation. This categorisation is found in an academic or professional text such as DSM-IV-TR.

One finds that in DSM-IV-TR the word “psychosis” is a broad concept that involves a number of conditions such as delusional disorder, schizophrenia, brief psychotic disorder, and schizoaffective disorder just to name a few (American Psychiatric Association, 2000). On the other hand, Zulu people use the word ukuhlanya as an equivalent to psychosis in general or schizophrenia in particular. Washington (2010) confirms this idea by using the word ukuhlanya and schizophrenia synonymously in his research project as well. There were no subcategories of ukuhlanya, which were assigned their own separate terms reported by the Zulu-speaking participants who participated in this research project, as it is the case with “psychosis” from a western point of view. In the experience of the researcher which was later confirmed by traditional healers who participated in this study, ukuhlanya and psychosis have a lot more in common than not. Nevertheless, obvious differences in terms of the conceptualisation and attributed causal factors of this condition from western theoretical frameworks like psychiatry and clinical psychology and Zulu belief system are noted and discussed later.

Mostly, when English-speaking people use the word psychosis or insanity and Zulu-speaking people use the word ukuhlanya, they are referring to a condition that presents with similar symptoms. In this research project, the word ukuhlanya refers to how it is commonly used by Zulu-speaking people of Zululand area, this being to refer to what is termed madness or insanity in English or psychosis in psychology and psychiatry.

There were a number of alternative Zulu words that traditional healers used to refer to their medicine. For instance amakhabi and imithi (herbal medicines) or izizwe, izinyamazane and amagobongo, (mixture of both animal and herbal medicines) just to name a few. Most participants (healers) believed that the function of traditional Zulu-medicine is to “heal” or “cure” a person who presents with the condition ukuhlanya by counter-acting the wicked spirits or substances inflicted on the sufferer/victim. The aim of healing is to return a sufferer’s mind back to its normal functioning. Another group of participants (caregivers) confirmed that the role of traditional medicine is to cure the illness of ukuhlanya. Caregivers confirmed this by giving an account of their relatives who once presented with this condition and were healed by traditional medicine.
The second main theme involved the view that the effectiveness of traditional Zulu-medicine in healing *ukuhlanya* is determined by the causal factors of this condition which may differ from person to person. Traditional healers mentioned that whether their medicine works to heal a person or not is mostly based on what caused this condition in the first place.

The third theme involved the notion that the traditional healers’ ancestors confer upon the traditional healers the wisdom to know what kind of medicine heals a particular person who presents with the condition of *ukuhlanya*. Most traditional healers who participated in the study confirmed that there is no specific kind of traditional Zulu-medicine that is preordained to cure *ukuhlanya* without taking into account the causal factors. Participants (healers) maintained that their ancestors either pass wisdom to them during the ritual of *ukuhlola*, in a form of a dream, or just before the person comes to their consultation rooms. The wisdom guides healers into *umuthi* (singular form for *imithi*) or *amakhabi* (plural for *ikhambi*) that they need to mix or combine in order to heal the person presenting with this illness. During the process of *ukuhlola*, healers learn the cause of the illness and the procedure to follow in order to help the sufferer.

The fourth theme encompassed the reported recovery period of people suffering from *ukuhlanya* who consult traditional healers. Most traditional healers who participated in the study stated that the recovery period of psychotic people who consult healers ranged from a few hours to a number of months. Caregivers who participated in the study confirmed part of this.

Each of the two set of participants had only one pre-determined question to answer. Follow up questions were based on their initial responses. A theme was chosen which was the traditional healers’ and caregivers’ views on the role of traditional Zulu medicine on psychosis. Follow up questions on this theme were intended to encourage the healers and caregivers to elaborate on their responses. This gave the researcher a deeper understanding of the participants’ attitudes and beliefs around issues that emerged during the interviews.

The above-mentioned themes are presented in detail in this chapter. The extracts as quoted verbatim from the participants, typed in italics, with the important terms and words in bold type.
4.2 Function of Traditional Zulu-medicine on psychosis (Theme 1)

Most traditional healers confirmed that the function or role of traditional Zulu-medicine is to “heal” or “cure” psychosis. By healing/curing, healers elaborated that it means removing the condition altogether so, it ceases to exist. Most healers reported that most of the time, when they use their medicine to heal a person who suffers from ukuhlanya, the main aim is to cleanse or purify the mind, which has been inflicted with wicked spirits. This issue is demonstrated by the following extract from one of the participants:

Because people who present with symptoms of psychosis usually find it difficult to comprehend and follow instructions, we usually find a way of grabbing them and then inserting umuthi through their nostrils and ears with the intention of purifying or cleansing their minds. The main aim is get the mind back to its normal functioning again.

Another healer was quoted saying:

Because a psychotic person cannot follow instruction of taking the medication by a steam bath (ukugquma), enema or laxative (ukuchatha) and vomiting from purgatives (ukuphalaza), as a healer you have to keep on inserting the medication in his/her ears and nose like you would do with a person who’s undergoing the ritual of ukuthwasa. As a healer, you endeavour to get the mind (ingqondo) back to its normal functioning.

Another participant mentioned that:

Izinyamazane, umbhemiso (medicines that have to be smoked or inhaled), umkhothiso (medicines that are licked) are all the things I use to heal people abahlanyayo (psychotic) with an aim of getting that person’s mind (ingqondo) to its normal functioning.

To demonstrate how traditional-medicine works on a person’s internal system to remove wicked substances that are causing the illness, one of the participants stated that:

A number of animal and herbal medicines are mixed-up which together form umuthi with a strong odour. This combination is then kindled with fire so that its smoke is inhaled by a person who presents with the condition of ukuhlanya. The effect of this kind of umuthi is that it makes a psychotic person vomit and produces a foam-like substance from the nose and mouth. This is the filth and dirt, inflicted on the person by those with evil and wicked intentions, which comes out this way. After this, I make the person lick (ukukhotha) umuthi.
4.3. Effectiveness of medicine depends on causes of psychosis (Theme 2)

Most healers admitted that not in all the cases does their traditional medicine succeed in curing ukuhlanya. Healers mentioned that their traditional medicine has the highest rate of success in curing “psychotic-like symptoms” that are inflicted on the person by his/her ancestors. One of the traditional healers made the distinction between ukuhlanya and ukuphanjanelwa yikhanda, which was confirmed by other traditional healers. This healer stated that a person, who is uhlanya (psychotic), is led to present with this illness by other people who might have either bewitched or sent evil spirits to that person. Ukuphanjanelwa yikhanda, on the other hand, the person presents with similar symptoms to ukuhlanya, but symptoms are presumed to be caused by the person’s ancestors.

This distinction is evident in the following extract by one of the participants:

When a person who presents with psychotic-like symptoms (ophanjanelwa yikhanda) goes to a traditional healer, the healer receives spiritual messages from the ancestors indicating that the person is supposed to undergo a ritual of ukuthwasa. A healer should not lie and say that he/she will definitely heal the person, because that person’s ancestors might choose where that particular person is going to find help. In some cases, other people’s ancestors might resist and communicate that they will release the person from those symptoms at another period (idlozi lingasho ukuthi lizomkhipha ngonyaka ozayo). This might be the case if, for instance, that person’s family matters concerning ancestors are complicated (Ngoba mhlwawumbe khona izinto lay’khaya ezingalungile kahle emsamo). Unlike uhlanya who has been inflicted with a number of wicked spirits by certain people...

In the above extract the healer distinguished between ukuphanjanelwa yikhanda and ukuhlanya. The healer makes it explicit in the extract that when healers perform the ritual of ukuhlola, they receive spiritual messages from ancestors about whether the person’s symptoms are caused by that person’s ancestors (ukuphanjanelwa yikhanda) with the intention of making that person undergo the ritual of ukuthwasa to become a healer or the illness is caused wicked spirits from specific people in order to complicate that person’s life (ukuhlanya).
4.3.1 Psychotic-like symptoms inflicted by one’s ancestors

Most traditional healers were confident about the effectiveness of their medicine in healing a person who presents with “psychotic-like symptoms” caused by a person’s ancestors as confirmed by the healer during the ritual of ukuhlola.

One of the participants mentioned that:

A person ophanjanelwa yikhanda may present with symptoms such as an incoherent speech and a whole lot of other symptoms but these symptoms sometimes abate. When this happens, it is just a way of that person’s ancestors to communicate to other people that their intention is not to make the person sick or suffer. Unlike uhlanya who suffers endlessly… What’s more, a person ophanjanelwa yikhanda, his ancestors may suggest where he/she should go and find help. Such people may walk long distances to far away places being led by their ancestral spirits, where they will finally locate help.

Another participant affirmed that:

In most cases it is most definite that a person ophanjanelwa yikhanda because of abaphansi (another Zulu word for ancestors), will be healed by a traditional healer and then undergo a process of ukuthwasa.

Healers also mentioned that in the case of a person ophanjanelwa yikhanda, their medicine helps to alleviate the symptoms and then leads a person to go through the ritual of ukuthwasa. Furthermore, healers’ medicine may assist in performing a traditional ceremony (umsebenzi) for a person’s ancestors in order to ask them to release the person from the calling. This is in the case of a person not feeling comfortable with the prospect of living as a traditional healer. The consequences of this depends on the person’s ancestors. If the ancestors accept a person’s reasons for not accepting the calling, the person may be freed from ukuphanjanelwa yikhanda. However, if a person’s ancestors insist that he/she becomes a healer, and the person refuses, then the symptoms of ukuphanjanelwa yikhanda may become more acute.

4.3.2 Psychosis caused by wicked spirits

Most of the traditional healers who participated in the study stated that they can heal ukuhlanya with traditional medicine. Most of the healers added that ukuhlanya which in their belief is usually caused by either bewitchment or other forms of wicked spirits, is curable but challenging.
To demonstrate his confidence in his ability to cure ukuhlanya, one of the healers is quoted in the following extract:

*You see, if you can bring uhlanya right now in this room, I will tie his legs and arms and then make him inhale, sniff and drink my medicine, and then he will leave this room as though he has never been ill.*

Another participant demonstrated his experience in healing ukuhlanya in the following way:

*It is curable, because if a person is psychotic and I combine certain parts of specific aggressive wild-animals, herbs and plants as well as other substances from the sea; the person will ‘awaken’ (umuntu uzovuka) from psychosis... It is highly unlikely that the person won’t be healed... There is only one person I have failed to cure and I told him that there was a conflict among his ancestors that needed to be sorted out first. I got to know about that while I was performing the ritual of ukuhlola... There are a lot of people I have healed who were severely psychotic... Sometimes I see these people progressing in life. For instance, some of them have built mansions for themselves, and I quietly say to my self, “hey, this is the person I have helped”. Some of them come to me after a long period of time since I had healed them, just to thank me; and I find it difficult to recognise them because of the change and progress in their lives.*

Participants mentioned that ukuhlanya is a challenging condition to heal because it has many causes. The healer has to understand the cause of the person’s illness first to stand a better chance of healing that person’s condition. Among other reasons described by healers as to why people would be bewitched or inflicted with evil spirits which lead to full-blown psychosis are: having stolen from others (ukuntshontsha), and progressing and being successful in life which may evoke feelings of envy (umona) and hatred (inzondo) in others. Healers mentioned that there are a number of life events that can stimulate feelings of envy and hatred in some people towards others and this may lead to an idea of complicating another person’s life (like inflicting psychosis). A healer described an example of people who had been dating who then separate and one partner develops feelings of hatred and goes to a traditional healer to ask for umuthi to make his/her ex-partner psychotic.

One healer made a distinction between umelaphi wendabuko (traditional “healer”) and umthakathi (a “witch”). He stated that a “real” healer does not send evil spirits on other
people. Instead his/her sole driving force is to promote life and harmony in the community. He added that it is challenging to work as a “healer” in the community. This is because other people who promote evil spirits in the community end up hating the “healers” because those who had been bewitched usually go to the “healers” for help.

A healer who referred to himself as a herbalist (inyanga) did not distance himself from sometimes using inithi to help other people achieve their self-centred goals at the expense of others. He gave an example of a man coming to him saying he loves a specific girl and wants her for himself. The healer described that he would use inithi and then assure the man that in a few days he would have that woman. According to the researcher’s knowledge, as a person who resides in the Zululand area, a person who has been made to do such a thing against her/his will is said to be a victim of ukudliswa (verb) rather than ukuthakathwa (bewitched). The malicious spirits of idliso (noun) might be sent on the victim while he/she is asleep, and enter his/her system through a dream if the victim is in a distant place. In a case of a victim and perpetrator who have constant contact with each other, idliso might be put in the victim’s meal while the victim is not paying attention.

This healer added that a person might come to him to request he complicates his/her ex-partner’s life. He mentioned that he would use izizwe (type of medicine) to help that person achieve his/her goal. In this case, people of the Zululand area would refer to the victim as having been bewitched.

To demonstrate that it is challenging at times to heal a person on whom evil spirits has been sent, one of the healers was quoted:

...In some cases you find that the person had been bewitched with a mixture of plants and parts of animals that are not easily accessible in our country. In other cases, the plant used may have been dug in an isolated, secrete place. If a person had been bewitched with things from distant places, which are difficulty to obtain, it becomes an insurmountable task to heal that person. This is because as a healer you have to travel to that place and mingle with people or healers of that community to find out what they usually use to heal a person who had been bewitched with substances of that particular region... However, if you have done your thorough investigation, travelled or made other means to obtain inithi that were either used to bewitch the victim or those that are needed to heal, you can easily heal the victim.
In the above extract, the healer demonstrates that some people use imithi that are from distant places so that it would be difficult for a victim to obtain help in his/her immediate environment.

In worse situations, healers mentioned that some of the people who present with the illness of psychosis cannot be healed by someone else other than the person who sent the evil spirits. One healer was quoted demonstrating this event:

*In other cases, if for instance one partner wants his/her (ex-) partner to be bewitched and become psychotic, among other things I can use isalamuzi lomchamo (a resemblance of the bewitching partner’s urine). If I include this in the mixture (ezintweni engizithakayo), the person who is bewitched is compelled to come back to me as well as the bewitching partner for help. No-one else can heal that person, because, where are they ever going to obtain the urine of the person that was used?*

The above extract demonstrates the shared view by most healers who participated in the study that traditional medicines’ success in healing psychosis relies on what was mixed during the act of bewitching the victim.

Healers mentioned another reason why and how other people may be bewitched and became psychotic. They revealed that it occurs when a person has injured someone, and the injured person consults someone (witch) to send evil spirits on the person who inflicted the injury or wound (*umthakathi asebenze isilonda*).

### 4.4 Healers receive wisdom from their ancestors (Theme 3)

All the traditional healers who participated in the study confirmed that they received their knowledge about the causes of psychosis and the kind of medicine that needs to be utilised in each victim from *their ancestors (izithunywa zabo)*. This kind of knowledge or wisdom is said to be passed down to the healers from *izithunywa* (ancestral spirits that guide each healer) in different ways. Most healers mentioned that they received this knowledge during the ritual of *ukuhlola*. Healers such as herbalists (*izinyanga*) and diviners (*izangoma*) stated that they usually use stones and bones to communicate with the ancestral world to get these answers. On the other hand, faith healers (*abathandazi*) usually use holy water (*amanzi athandazwele noma abusisiwe*). Some healers who referred to themselves as either herbalists or diviners, mentioned that they also use holy water to do most of their work. Most healers
mentioned that they perform the ritual of *ukuhlola* in a cross-legs position while the victim is also in the same room sitting down on the floor.

Some healers mentioned that they might learn about a person’s condition and type of medicine to use through a dream while asleep. They acquire the wisdom of knowing about the person’s condition and where they can obtain the medicine to cure the person while asleep near to the day the person comes to their work place. Knowledge about a person’s condition can also be known by a traditional healer in the absence of the sufferer. A healer mentioned that a prominent difference between traditional healers and healers whose approach is based on the western worldview is that, the former can see beforehand what brings a person to them. The same healer stated that sometimes a person does not even have to say what his/her problem is because a traditional healer will already know that before it is even said. Even if the knowledge is passed to the healer through a dream, it is believed to be coming from the healer’s ancestors.

4.4.1 Knowledge about the cause of the person’s illness

During the ritual of *ukuhlola*, the spirits of the ancestral world speak through holy water, bones or stones about what happened to the victim leading up to the condition of psychosis.

In the following extracts traditional healers explain what happens when a person *ophanjanelwa yikhanda* comes to a traditional healer for help:

*It is said during this process that this person has been occupied or possessed by amandiki namandawu, amanono, abalozi* (spirits that possess a person who is to become a healer), or *idlozi* (ancestors)…

The above extract refers to what happens during the process of *ukuhlola* if a person’s symptoms are inflicted by his/her ancestors.

Another healer explains this phenomenon in the following way:

*When a person ophanjanelwa yikhanda or uhlanya comes to you as a healer, you make amagobongo (mixture of both herbal and animal medicines) for that person and then amagobongo will talk and communicate with whatever that has possessed that person. For example, what has possessed the person might say, “it is me so and so…this is how I happened to posses you, and this is what I want from you...”*
From the last extract it is explicit that some healers use *amagobongo* to communicate with whatever that has possessed the person leading to either *ukuhlanya* or *ukuphanjanelwa yikhanda*. *Amagobongo* are reported to speak to what has possessed the person while the healer is listening. This is further evidence of wisdom passed to a healer by his ancestors.

**4.4.2 Knowledge about the medicine to use**

Each traditional healer is uniquely guided by his/her ancestors into the knowledge of plants and animals that may heal different kinds of illnesses. Most healers stated that even though there are specific kinds of herbs and plants as well as parts of wild animals that when mixed together are commonly known to heal psychosis, there is no specific one type of medicine that cures psychosis. Most healers in the study mentioned that psychosis could be caused by a combination of a number of substances (herbal and animal bits and pieces). Therefore, the medicine needed in each case may vary. The specific plants and animal parts to combine in each particular case may be decided by *idlozi* of the traditional healer.

To demonstrate this phenomenon one of the healers was quoted saying:

> Sometimes when I am dealing with a complicated case of psychosis, my ancestors show me through a dream in my sleep the place where I can find a specific plant that I have to go and dig to heal that particular person.

Most healers mentioned a number of herbs, plants, and animal parts which may be used to heal psychosis, but all of them agreed that there are as many ways of treating psychosis as there are causes.

Another healer mentioned that:

> When a person is suffering from psychosis, certain parts of *izinyamazane* (medicine made with parts of wild animals) such as *isinkwe*, a bird that eats chicken... (could no recall its name), *isikhova* (owl), *uxamu* (iguana), *imbulu* (monitor lizard), a snake that does not have eyes...*umsenene* (mole snake), *ihobosha* and did I also mention *inkawu* (monkey)? *Ingungumbane* (porcupine), as well as *umansagwana* are some of the things they mix together. All these things are burnt up to become *izinsizi* or *umlotha* (ashes) and they produce a bad odour...This kind of combination is made to be inhaled by a psychotic person (*uyashunqiselwa*) and then the person will get dizzy as if he/she was drunk (*adakwe*). Once
a person is in this state, the filthiness (udoti) that was used to bewitch him/her will get out of his/her system in a foam-like substance...

Another healer mentioned his own unique combination in the following way:

Aggressive wild animals...that fight and are stubborn such as izinyathi (buffalo), obhejane (rhino), and ododwane, even izimamba (snake). Animals of that sort, which have an inherent hostile nature as well as amakhabi or izingxabi (roots of specific plants). There are also plants that have a hostile nature...You also add ovuka. This combination might be used to bewitch a person to become psychotic. Similarly, when you heal that person, you use the same combination and add other parts of animals that you know can do the job, as well as other objects that are found in the sea.

To demonstrate the unique abilities that each traditional healer has endowed on him/her by his/her ancestors, a healer is quoted saying:

I have had an experience of healing people who presented with the illness of ukuhlanya. However, because this is a complex condition that cannot be treated by anyone who claims to be a healer, I have a special person that I usually refer such people to. This person is well equipped on how to treat ukuhlanya...

Another healer expressed why healers should not guarantee that they could heal any condition including ukuhlanya because traditional medicine and healing depends on each healer’s abilities which in fact relies on the healer’s ancestors.

A healer should not guarantee that he/she can heal any condition; because each healer has his/her own strengths when it comes to medicine and healing...For example I refer to myself as a faith healer (umkhokheli) as well as a diviner (sangoma). Religious wise, I can pray and prophesy using holy water and at the same time I can perform ukubhula (another word for ukuhlola which is commonly used by diviners) and tell the person the cause of the illness and cure the illness through traditional medicine (imithi yesintu).

One healer admitted that he does not have enough knowledge about the causes and treatment procedures for people who are suffering from psychosis. He described another healer who is knowledgeable and well-experienced on the subject and who can heal people who present with this condition. This healer stated that he is well-equipped with healing other forms of
illnesses but not ukuhlanya. He added that his grandfather, who was a herbalist (inyanga) passed away and left him to continue with traditional healing.

4.5 Recovery period of people who suffer from psychosis (Theme 4)

There was no consensus among the healers about the specific recovery period for people who are suffering from psychosis after starting traditional medicine. However, most healers agreed that it depends on the cause of the illness and how long a person has been presenting with the symptoms of ukuhlanya.

4.5.1 Healers views on the time of recovery

One healer mentioned that if a person has been suffering from this illness for a period of at least five years, that person could not be healed. This is demonstrated by the following extract:

...psychosis is curable with traditional medicine. However, if a period of 5 years has elapsed since the person started presenting with ukuhlanya, that person cannot be healed...

A healer declared that it depends on the case. In one case it may take sometime and in another it may take a short period:

To heal uhlanya I can say it takes a while or I can also say it doesn’t. It depends on the herbal (imithi) and animal (izinyamazane) medicines you have combined or mixed together (ugaye wacina kuphi)...It also depends on what was combined in making that person psychotic...

A healer confirmed that healing takes a long time and that she also teaches the sufferer socially adaptive skills:

Hah...hah...!(overstressing and expressing the challenge she faces when healing someone who has this condition) It is difficult because when people make another one to become psychotic, they mix-up all sorts of wicked things...its takes a long time to heal uhlanya (luyadonsa uhlanya)...I do a lots of things with people who are psychotic like teaching them how to write and sending them to buy some things for me in the shops just to check the progress of the healing process...If a person is healed by a traditional healer his/her condition cease completely, in such a way that other people can’t even get an idea that he/she was once psychotic.
A healer expressed his confidence in healing this kind of illness, by stating that within a few minutes or hours he could make *uhlanya* recover:

*You see, if you can bring *uhlanya* right now in this room, I will tie his legs and arms and then make him inhale, sniff and drink my medicine, and then he will leave this room as though he had never been ill.*

Some healers mentioned that healing *uhlanya* takes weeks and some mentioned that it takes months. Only one healer demonstrated his confidence that he can heal *uhlanya* within a few minutes or hours.

### 4.5.2 Caregivers’ views on the recovery period

One caregiver explained that her only son from a polygamous marriage, who was doing well at school, was bewitched with evil spirits by a person whose identity she could not reveal. The caregiver took her son to a well-known healer in the area (who was also one of the participants in this study) for treatment. The caregiver revealed that the healer’s medicine was successful in healing her son in a period of approximately three weeks. The son, who was reportedly presenting with the illness of *ukuhlanya*, was then sent away to live with his aunt in a city. The caregiver added that the reason why she decided to send her son to live in a city with a relative was because she believes that there are fewer instances of bewitchment in a city centre than in her rural area. She further mentioned that her son is currently pursuing his studies as a medical doctor in one of the South African Universities. This caregiver related her story in the following way:

*Ey! Witches my child (addressing the researcher) can destroy other people’s lives. My son was bewitched with evil spirits by a person who is around this yard as we speak, who I will not reveal…That person was envious of my son who had passed grade 12 with flying colours and was about to start his studies at the University…Evil people do not want to see other people progressing in life. I thank God *(Unkulunkulu)* and… (mentioning the name of the healer who helped her son) for assisting him…You should also be careful my child because a lot of people might not be happy as you are studying to become *udokotela wezenqondo* (psychologist)…*
The second caregiver mentioned that her younger sister, who passed away years ago, left her with a male child who she believes was bewitched with wicked spirits because he was a known thief in the area. The caregiver then took that child to one of the healers (who was also one of the participants in this study). She added that this child recovered from full-blown psychosis after about a month of constant consultations with the healer. She mentioned that the child’s life thereafter changed.

This healer related her story in the following way:

*My sister (udadewethu) passed away and left me with her son. People were swearing at me that they were going to kill him because he was a troublesome boy in the community. He once raped a girl and stole goods repeatedly from the neighbours. Finally, people bewitched him and became psychotic (bamhlanyisa). It never came as a surprise to me because I used to say to him that people will pay their revenge on him brutally, but he never listened to me (bengihlala ngimtshela ukuthi khona okusina kunjeqza kodwa engangizwa). I then took him to... (mentioning the name of the healer) who helped him with his medicine (amakhambi akhe). In about a month’s time, he recovered fully and after a while, he got a job in one of the industries in Richards Bay...*

**4.6 Summary**

This chapter presented the results of the study. Four main themes that emerged during the analysis of the results were discussed. The first theme described how traditional Zulu medicine heals or cures the illness of psychosis until it ceases to exist. This theme further highlighted how traditional medicine is used to counteract wicked spirits that have been inflicted on the psychotic person with the aim of purifying the sufferer’s mind.

The second theme encompassed the reported effectiveness of traditional Zulu medicine in treating psychosis. Most healers stated that the effectiveness of their medicine in curing psychosis, depended mostly on two factors. These factors were the causes of ukuhlanya and the length of time that the person had presented with the illness. Most healers expressed their confidence in traditional medicine (amakhambi esintu) to heal most cases of ukuhlanya.

The third theme that emerged during the analysis of data involved the belief that healers receive spiritual wisdom from ancestors (abaphansi) as to the causes of a person’s illness as well as the medicine (amakhambi) that they ought to use to heal the sufferer.
The fourth theme consisted of the recovery period of people suffering from the condition of psychosis who consulted with traditional healers. There appeared to be no specific recovery period for psychotic people who consulted a traditional healer. Recovery seemed variable in duration. Nevertheless, most healers agreed that it could range from a few weeks to a few months depending on how long the person has been suffering from the illness and what the healer has put together to heal the sufferer. In addition, caregivers confirmed that traditional medicine had healed their relatives and that the recovery period ranged from weeks to months.
CHAPTER 5

CONCLUSION

5.1 Introduction
In this chapter, the results of the study are discussed against already existing literature and sentiments of the researcher. Obstacles encountered during the process of the study and the transferability of the results will also be discussed. Following that, what emerged as what might benefit both the community of the Zululand area in KwaZulu-Natal and the field of psychology in general and indigenous psychology in particular will be presented. This chapter is ended by recapping on what is entailed in this research project from the first chapter to the final one.

5.2 Main Findings

5.2.1 The role of traditional Zulu-Medicine is to heal psychosis
It was fascinating to learn that most Zulu traditional healers believe that if traditional medicine is used on a psychotic person, the aim is to heal the illness by making it cease to exist. This belief was supported by caregivers of the persons who consulted the healers while they were suffering from the illness of ukuhlanya. The role of traditional medicine seems to differ from the role that is played by psychiatric medication on symptoms of psychosis (ukuhlanya/schizophrenia). It is according to the researcher’s understanding that in most clinical psychiatry and psychology literature, anti-psychotic medication is usually presented as playing the role of alleviating the symptoms rather than curing the disorder of psychosis, specifically schizophrenia. In other words, from a western point of view, this debilitating condition is believed to be manageable with both psychotherapy and anti-psychotic medication rather than curable.

Halgin and Whitbourne (2007, p. 299) maintain that while current understanding of the causes of schizophrenia remains incomplete, scientists continue to look for ways to alleviate its symptoms. “The consensus is that an integrative intervention that includes medication, psychological treatment, and social support provides the best context for helping people with schizophrenia” (Halgin, & Whitbourne, 2007, p. 299). Starting with biological approach, there is persuasive evidence for the important role of medication in alleviating the distressing
symptoms of this disorder (Halgin, & Whitbourne, 2007). At the same time, it is important to bear in mind that medication does not cure the disorder but only treats the symptoms (Halgin, & Whitbourne, 2007, p. 299).

To further demonstrate the understanding of psychosis in general or schizophrenia in particular in the field of psychology and psychiatry, Halgin and Whitbourne (2007, p. 299) mentioned that “Just as biology is an insufficient explanation for the disorder, medication is an incomplete intervention for treating people with schizophrenia. Individualised treatment plans range from tightly structured institutionally affiliated programs to periodic psychotherapy that is provided when needed. Generally, those who are incapacitated by the disorder require comprehensive and permanent treatment and support. But many people with schizophrenia function adequately in the world and need active intervention only on occasion, when psychotic symptoms flare up”.

To convey the nature of this condition, Cancro and Lehman (2000) (cited in Panksepp, 2004) affirmed, “schizophrenia is a chronic, frequently lifetime, remitting, and relapsing psychotic disorder with prominent symptoms and deficits even during the phases of remission”. These views seem to differ from the commonly held belief by most Zulu-traditional healers that psychosis is a treatable condition to the point that it cease to exist. Nevertheless, the psychology and psychiatry view that psychosis, particularly schizophrenia, is not a curable disorder is to some extent similar to what was reported by other Zulu-traditional healers that ukuhlanya, in which inaccessible “material” was used to bewitch the sufferer, is usually incurable.

5.2.1.1 Differences in roles of Anti-psychotics and Traditional medicine on psychosis

The following extract was cited directly from Halgin and Whitbourne (2007, p. 295-296) to demonstrate the nature and role of antipsychotic medication on psychosis (schizophrenia).

“There are a number of categories of antipsychotic medication, which are also called neuroleptics. In addition to their sedating qualities, neuroleptics reduce the rate of recurrence and severity of symptoms of psychosis. Different neuroleptics differ in the dosages to achieve therapeutic effects, ranging from low-potency medications that require large dosages to high-potency medications that need relatively smaller dosages. The low-potency class includes such medications as thioridazine and chlorpromazine; middle-potency medications include
thiothixine and trifluoperazine; high-potency medications include haloperidol and fluphenazine.

A medical doctor would be more expected to prescribe a low-potency medication for a highly agitated patient, because low-potency medications tend to be more sedating than the high potency ones. The high-potency medications may be preferable for a patient who is less agitated, but they do hold the risk for more severe side effects. These conventionally prescribed antipsychotics have their effects through the blocking of dopamine receptors. In different terms, antipsychotics contain chemical substances that become attached to the sites on the neurons that would regularly react to the neurotransmitter dopamine. This action has two behavioural consequences, one therapeutic and the other, unintended and bothersome. The therapeutic effect is the reduced frequency and intensity of psychotic symptoms, as the dopamine receptors are deactivated in the sections of the brain that affects thought and feelings. On the negative side are results that can greatly interfere with the individual’s movement and endocrine function.

Troubled by the frustrating side effects of these traditional antipsychotic medications, as well as their futility in treating negative symptoms, psychopharmacological researchers set out to develop new medications. In recent years, medications called second generation antipsychotics have been more extensively prescribed. Examples of second-generation antipsychotics (SGAs) include amisulpride, clozapine, olanzapine, risperidone, quetiapine, and sertindole. SGAs have their own side effects involving metabolic disturbances, particularly weight gain and hyperlipidemia. In a meta-analysis of studies comparing the efficacy of first-generation antipsychotics (FGAs) and second-generation antipsychotics (SGAs), researchers found that some SGAs are considerably more efficacious than FGAs, but some SGAs are no more efficient than FGAs.”

Upon analysing the information that was provided by Zulu-traditional healers who participated in the study, it emerged that a mixture of both herbal and animal medicines such as amagobongo, izizwe and izinyamazane are used to curb the evil spirits that have been inflicted on the person by people with ill intents such as abathakathi. When the wicked spirits inflicted through witchcraft are removed, the person’s mind is believed to be cleansed with an aim of getting it back to its normal functioning. By looking at the role of traditional medicine and psychiatric medication from this dimension, it seems as if it is both targeting to sort out
something in the brain. For instance, antipsychotics are said to be aiming to regulate the overproduction of the neurotransmitter dopamine, in the brain (Halgin, & Whitbourne, 2007). On the other hand, imithi yesintu (traditional medicines) are said to be aiming to retain the brain’s previous “normal” functioning (ukubuyisela ingerdondo esimweni sayo).

From another dimension, the role of traditional medicine and antipsychotic medicine differ. For instance, traditional medicine seems to be aiming to remove a “foreign body” or “wicked spirit” that is believed to have possessed the person’s system and affecting his/her mental functioning. On the other hand, antipsychotic medication seems to be aiming to alter a person’s innate, relatively biologically-wired “faulty” brain chemistry. By “biologically-wired”, the researcher is not implying that psychosis is an inborn condition that the sufferer is definitely bound to suffer from, just because it is part of his/her genetic make-up. The stress-diathesis model solves this common misconception.

The stress diathesis model is of the contention that some people are born with a predisposition that puts them at a risk of developing a mental disorder (Halgin, & Whitbourne, 2007). This predisposition usually depends more on the environmental factors that might either activate or de-activate it. McWilliams (2012, p. 159) maintains, “genetic dispositions can be skewed by early experience, genes can be turned on or off, brain chemicals are altered by experience, and everything interacts”. For instance, if one has a first-degree relative who suffers from schizophrenia, one may be at a higher risk of suffering from the same condition if enough stressful environmental events trigger it, because of one’s possible biological propensity/proneness to it. There are a number of counter-arguments against this model. However, because it is not the aim of this chapter to explicitly explain this model in order for the reader to grasp the full understanding of the model, those arguments would be left open. The point is, Zulu traditional medicine seem to aim to remove something that is “foreign” which has been inflicted on the victim who is psychotic, whilst on the other hand, anti-psychotics are believed to be dealing with the symptoms related to “innate” defective brain chemicals.

In addition, whilst the psychology and psychiatry literature talk of the treatment of “symptoms” rather than the “disorder” of schizophrenia (Halgin, & Whitbourne, 2007; Sadock, & Sadock, 2010; World Psychiatric Association, 2005), Zulu traditional healers talk of healing this “illness” to the point of making it end. In simple terms, western mental health
care practitioners claim to treat the symptoms of schizophrenia whilst Zulu traditional healers claim to treat the illness of ukuhlanya as such. At this point, it appears as if it is crucial to look at this issue within the context where it is taking place. First, traditional healers reported that they can heal psychosis and this was confirmed by caregivers of persons who once consulted some of these healers while they were suffering from this condition. Secondly, on the other hand, western mental health care practitioners report that schizophrenia is not a curable disorder but its symptoms are manageable. Perhaps the key to this issue lies with the actual not suspected causes of this condition. Perhaps, psychosis that responds to Zulu traditional medicine is the one that is “actually” caused by Zulu traditional factors such as bewitchment. On the other hand, perhaps schizophrenia that is “actually” related to defective brain chemicals is the one that responds better to anti-psychotic medication and psychotherapy. This way of viewing these phenomena eliminates the debate about which group of practitioners are better equipped in treating this condition. Perhaps this condition responds better to treatment that is in accord with its contextual causal factors. There is logic in the assumption that a condition that is caused by biological, social as well as psychological factors will respond better to a western biopsychosocial treatment and the one that is caused by wicked spiritual factors will respond better to a traditional, spiritually led approach.

It should not be overlooked that some traditional healers who participated in this study reported that ukuhlanya (psychosis/schizophrenia) is not completely curable by western approaches but can be cured through traditional medicine. One healer even made an example of one of her relative who was once sent to one of the psychiatric institutions for a long period but his condition never subsided. She reported that he was finally healed through traditional means. Such claims might be true, however, one needs to view them with scepticism because there is no persuasive evidence that psychosis that is either related to defective brain chemistry or bewitchment responds better to traditional Zulu medicine as compared to western medical and psychological approaches.

Traditional healers mentioned that ukuhlanya can also run in families, not because of genetic predisposition, but because evildoers have used certain substances, they dug up on the burial place of one of the long-dead relative of the targeted family (kumbiwa izithixo noma izidalwa zakulowo mndeni othakathwayo) to bewitch members of that family. This finding contradicts what Washington (2010) reported that Zulu people classify ukuhlanya as a genetic disorder. Even in this form of familial psychosis, the role of medicine is to retain affected family
members’ brain functioning to their regular states. How this form of psychosis is treated will also be in accord with how it was “created” by the evildoers.

5.2.1.2 No specific medication is certain to cure psychosis alone

Most traditional healers who participated in the study reported that there is no specific medicine, which is preordained to cure psychosis. However, there are many ways as well as animal- and herbal-medicines that are put together to cure ukuhlanga. This is partly similar to the fact that even in psychiatry, there is not a single drug that is certain to heal any form of psychosis regardless of the symptom presentation (Kay, & Tasman, 2006). There are a number of antipsychotic medications that are designed to alleviate the symptoms of psychosis in general and schizophrenia in particular, depending on factors such as the severity of symptoms and prominence of specific symptoms.

Furthermore, one of the traditional healers revealed that in addition to medicine, she teaches her psychotic clients social adaptive skills such as sending them to buy items from the shops, cooking and collecting woods from the forest to make fire (ukutheza). This healer confirmed that she does this to verify the progress of her medication and improve her clients’ reality testing. This is closely similar to token economy used in Cognitive Behavioural Therapy for patients who suffer from schizophrenia. Halgin and Whitbourne (2007) confirmed that in token economy, mostly used in institutional settings, individuals are compensated with plastic chips called tokens for behaving in socially proper ways. In the field of psychology, it is commonly believed that if a specific behaviour is followed by a reward that behaviour is more likely to be maintained or repeated (Woolfolk, 2009). Similarly, this healer reported that she complements her clients if they have done what she instructed them to do accordingly.

Just like in Zulu-traditional healing, in the field of psychology there are a number of therapeutic techniques employed by different schools of thought within this field. For instance, Mace and Margison (1997) and Gleeson and McGorry (2004) discuss psychodynamic and psychoanalytic, cognitive-behavioural, systemic and family, and integrative psychological approaches to treating symptoms of psychosis. Nevertheless, these approaches will not be discussed in this project.

Most healers and caregivers who participated in the study seemed to perceive ukuhlanya as a dysfunction of the brain or mind. For instance, when referring to uhlanya they frequently
used statements such as *ukuhlanya ngengqondo* (equivalent to English word *mental insanity*), *ukuphanjanelwa yikhanda* (spinning of the head), and *ukugula ngengqondo* (sick in the head or brain). This view appears to be in accord with what is commonly believed in psychiatry. For instance, the dopamine hypothesis is of the contention that positive symptoms like hallucinations, delusions and attentional deficits can be attributed to an overactivity of neurons that communicate with each other by means of the transmission of dopamine in the brain (Halgin, & Whitbourne, 2007). Note that at times during the course of the interviews, healers used the words *ukuhlanya* and *ukuphanjanelwa yikhanda* interchangeably to refer to psychosis; however, they insisted that only the latter word can be used to refer to “psychotic-like symptoms” that are present in people who have received a calling to become healers.

Zulu traditional healers who participated in the study revealed that when psychotic people are having hallucinations and delusions, the things they do such as “conversing with themselves” and taking off their clothes in public, are actual conversations and instructions that they receive from the wicked spirits (*imimoya emibi*) or *izilwane* (animals) that were inflicted on them. This is not in line with the commonly held belief in psychology and psychiatry that the delusions and hallucinations that psychotic people present with are a product of their own minds whose reality testing is impaired (Feldman, 2006).

In other words, from Zulu traditional healers’ point of view, hallucinations and delusions are a product of the wicked spirits that live within that person which were inflicted by others. From a psychological and psychiatric point of view, hallucinations and delusions are a product of a person’s own mind, whose contact with reality is distorted (Feldman, 2006; Halgin, & Whitbourne, 2007; St. Clair, 2000). In other words, according to psychology and psychiatry literature, nothing is “inserted” in the psychotic person’s mind by others, but delusions and hallucinations are a product of the sufferer’s own partly conscious and partly unconscious mental creation. McWilliams (2012) use the concepts “ego alien” and “ego syntonic” to describe the extent to which people who present with conditions such as psychosis might be (un-)aware of the pathological nature of their symptoms. McWilliams (2012) suggests that if a patient’s symptoms are “ego alien” the patient might have a favourable prognosis because it means that such as patient’s ego has a good capacity to acknowledge the pathological nature of the symptoms, whilst symptoms that are “ego syntonic” might predict an unfavourable prognosis because of lack of insight into the
disturbing nature of one’s condition. The latter might apply to the most cases of psychotic patients, whose ego capacity to respond to reality accordingly is distorted (St. Clair, 2000).

It is imperative to mention that even though most psychologists hold this last view and psychiatrists believe in the dopamine hypothesis, they nevertheless admit that the actual causes of psychosis are not known but a number of factors (Sadock, & Sadock, 2010) usually precipitates this condition. It is another debate whether the excessive dopamine production observed in the brain of a psychotic person is a causal- or contributing-factor, and whether psychosis precedes or follows this form of brain chemistry. This debate is not going to be discussed in this project. Even though traditional healers seem to share the same view with psychiatrist about what might be wrong with a person who is psychotic (i.e. something is defective in the brain), healers nevertheless believe that the causes of psychosis differ from what is commonly believed in psychiatry. More is mentioned about the causes of ukuhlanya under another heading in this chapter.

Gumede (1990) and Hopa (1998) (cited in Melato, 2000) were quoted mentioning that “the illness of thwasa which western practitioners regularly diagnose as psychosis came up in the majority of responses as an ‘African illness’ which the western healers are ‘unable to cure’. This illness can be identified by symptoms like delusions, hallucinations, lack of self-care, excessive and confusing dreams as well as incoherent speech. Within the theory of causation of illness, these symptoms represent as state of imbalance between the person and his/her ancestors. The only way to restore this imbalance is through the person’s acceptance of the calling to become a traditional healer. This should be done though an experienced traditional healer who would also act as a mentor for the trainee”. In addition, Melato (2000) mentioned that traditional healers who participated in his study, declared ukuhlanya as one of the conditions they are capable of healing. The last statement is in line with what was reported by traditional healers in this research project.

The ‘ukuthwasa illness’ mentioned by Melato (2000), seems to be exactly the same condition that presents with relatively similar symptoms as ukuhlanya which is referred to as ukuphanjanelwa yikhanda in this research project. In this study, healers preferred to use the word ukuphanjanelwa yikhanda instead of ukuhlanya for what Melato (2000) referred to as ‘ukuthwasa illness’. This is because the word ukuphanjanelwa yikhanda has fewer stigmas than ukuhlanya and that the former is caused by one’s ancestors not wicked spirits which
applies to the latter. Melato (2000) reported similar findings about this condition (ukuphanjanelwa yikhanda/ thwasa illness), that a person’s ancestors cause it. Healers, who participated in this study, believed that ukuphanjanelwa yikhanda is a condition that they can heal and that afterwards, in most cases, the person has to undergo the ritual of ukuthwasa. This is partly similar to what was reported by Melato (2000). It is similar in a sense that it is caused by one’s ancestors but different in a sense that the only way to cure this condition is by adhering to one’s ancestors’ request.

Healers who participated in this research project mentioned that a person might be healed from this condition by making umsebenzi (traditional ceremony) for abaphansi to either accept or ask to be released from the calling. In addition, these healers warned that if a person does not accept the calling, and his/her ancestors are not pleased with his/her reasons, the person’s condition might become more acute. In other cases, the ancestors might release the person from the calling if the person gives legitimate reasons to the ancestors during the traditional ceremony. If a person accepts the calling or even if he/she does not, but the ancestors insist that, he/she works as a healer, the person has to undergo the process of ukuthwasa.

African shaman (2012) mention that “isangoma is called by a particular ancestral-spirit. Being called is signified by being much troubled usually through bad dreams, pains in the shoulders, yawning, sneezing, sighing or faintness, this caused by the brooding (ukufukamela) presence of the ancestral-spirits. Only in accepting training as an initiate (ithwasa) can there be any cure, while failure to accept a call can result in madness (ukuhlanya).”

Note that African shaman (2012) contradicts the findings of this research project, in a sense that traditional healers who participated in this study reported that ukuhlanya is caused by bewitchment or sorcery, not ancestral spirits. However, bear in mind that the researcher reported earlier on that, healers “preferred” to use the word ukuphanjanelwa yikhanda instead of ukuhlanya for psychotic-like symptoms related to having received a calling to become a traditional healer. It remains an open question, whether healers preferred the former term instead of the latter solely because of its better connotation or they made this distinction for the sake of convenience and clarity to distinguish what is an illness and what is not. Otherwise, perhaps all these factors contribute to the preference of one term to the other.
According to the participants in this study, if a person does not adhere to the calling to become a healer, and that person’s ancestors persist that he/she does, that person’s symptoms of *ukuphanjanelwa yikhanda* were reported to become “acute”. However, no change of the terms was applied to refer to this “acute” condition like it was reported by African shaman (2012). It was noticeable that traditional healers in this study, did not associate symptoms related to becoming a healer with “*ukuhlanya*” nor did they associate these symptoms with “illness”.

As one of the people who grew up in the community that was interviewed, since the researcher was a child, people who surrounded him used the word *ukuphanjanelwa yikhanda* and *ukuhlanya* interchangeably to refer to a psychotic condition. Here the researcher is not referring to the day-today use of these terms in which they are used to tease one other or when someone does something that is regarded as uncharacteristic. However, the former term has fewer stigmas than the latter. This is based on the researcher’s experience and knowledge as a member of this community. The researcher admits that his knowledge might be subject to correction. These terms are like the general preference of the word “insanity” to “crazy” or “mad” in English. Moreover, African shaman (2012) contradicts the findings of this study by mentioning that the only way to heal the symptoms associated with having received a calling to become a healer is by adhering to the calling.

Edwards (2011) confirms that “an individual may receive a calling by the ancestors to become a diviner (*isangoma*), which is followed by a creative illness or religious conversion that occurs in many religious systems (*ukuthwasa*). This creative illness needs treatment either to bar the spirit (*ukuvala idlozi*) or to allow the neophyte (*ithwasa*) to undergo training to become a diviner under a qualified divine healer (*isangoma*)”. Edwards (2011) findings seem to compliment what was reported by traditional healers in this study, that when one is presenting with symptoms that are inflicted by one’s ancestors to become a healer, adhering to ancestors request is not the only way to deal with the symptoms. In contrast, African shaman (2012) complements Melato’s (2000) research findings that the only way to heal these symptoms is to adhere to the ancestors’ request. Otherwise, the person might become psychotic. Edwards (2011) and Melato (2000) seem to perceive *ukuthwasa* as an illness. However, a study conducted by Niehaus, Oosthuizen, Lochner, Emsley, Jordaan, Mbanga, and Keyter (2004) complement the results of this study that *ukuthwasa* is not an illness.
According to the information that was presented by healers in this research project, *ukuthwasa* is not an ‘illness’ per se as it seems to be reported in Melato’s (2000) study. *Ukuthwasa* is a form of ‘training’ or an internship that a person who has received a calling to become a healer has to go through under a qualified healer or diviner. What might be reasonable to refer to as an ‘illness’ usually precipitate the process of *ukuthwasa*. This is what was referred to as *ukuphanjanelwa yikhanda* in this study. However, healers who participated in this study warned that *ukuphanjanelwa yikhanda* that usually precipitate *ukuthwasa* is not an illness, neither is what usually follows this event, which is *ukuthwasa*. Nonetheless, Melato’s (2000) point of referring to *ukuthwasa* and as the “thwasa illness” and Edwards idea of using the word “*creative illness*” to refer to the same phenomenon might be because they view *ukuthwasa* with the psychotic-like symptoms (*ukuphanjanelwa yikhanda*) that usually precipitate *ukuthwasa* as occurring at the same time.

Edwards (2011) and Melato’s (2000) views might be valid because one of the traditional healers in the current study mentioned that sometimes the “psychotic-like symptoms” (*ukuphanjanelwa yikhanda*) that usually precipitate the ‘internship’ of *ukuthwasa* may be incurable and persist for a long period of time depending on when and how that particular person’s ancestors might want to release the person from the symptoms. Even so, the “symptoms” of *ukuphanjanelwa yikhanda* and the ‘internship’ of *ukuthwasa* that usually take place in succession are not exactly one unit that is an ‘illness’.

The researcher mentioned earlier on that a healer who participated in the this study assured that symptoms of a person *ophanjanelwa yikhanda* constantly abate. According to this healer, this is an indication by the person’s ancestors that they are not making him/her ill. In addition, the symptoms that a person who has received a calling to become a healer presents with are an indication of being possessed by ancestral spirits, not an illness. African shaman (2012) uses the word *ukufukamela* to refer to this phenomenon. In summary, while other literature might be suggesting otherwise, the results of this research project indicate that *ukuhlanya* is caused by other people such as *abathakathi* who have wicked intentions about the victim. On the other hand, those who present with relatively similar symptoms as *ukuhlanya* but which are actually inflicted on them by their ancestors are not *izinhlanya* (plural for *uhlanya*) but *baphanjanelwa amakhanda* (plural for *ukuphanjanelwa yikhanda*). Even if the latter does not accept the calling to become a healer, and his/her condition becomes acute, he/she is not *uhlanya* because the concept of *uhlanya* suggests a wicked
source such as bewitchment, which was not the intention of the ancestors in the first place. The way traditional healers demonstrated this phenomenon, it seemed to suggest that so long as the causes of a person’s condition are known in their cultural context, ithwasa should not be mistaken for uhlanya or even called that way.

5.2.2 The effectiveness of traditional medicine on psychosis

Most healers who participated in the study mentioned that traditional medicine’s effectiveness in healing psychosis depends on the causes of the illness. For instance, a person who had been bewitched with imithi that were imported from far away places and the one on whom things such as another person’s urine was used to bewitch him/her, cannot be easily healed or healed at all because of the “inaccessibility” of the substances that were used to bewitch them. The duration of condition was reported as another determining factor for the efficacy of traditional medicine in healing the illness of psychosis. This is to some extent similar to the commonly held belief in psychiatry and psychology that the favourable prognosis of a psychotic patient is determined by factors such as the treatment with antipsychotic medication soon after the onset of the disorder, among others (Halgin & Whitbourne, 2007).

Earlier on the researcher mentioned that both traditional healers and psychiatrists seem to perceive psychosis as a condition in which the person’s brain functioning is impaired, but they attribute this condition to different causes. Psychologists and psychiatrists may draw from a number of factors such as genetic predisposition, neural dysfunction, disturbed parent-child relationship, or biochemical factors (Kaap, 1991, p. 442-443) among others as contributing to the state of being psychotic. Nevertheless, these professionals admit that the causes of psychosis are unknown, nor do they claim to know how to cure the disorder (Halgin, & Whitbourne, 2007). On the other hand, Zulu traditional healers who participated in the current study stated that psychosis (ukuhlanya) that is caused by bewitchment or other ill-intents by other people, particularly using imithi they acquired from abathakathi is usually curable to the point of making the illness cease to exist. So both sets of practitioners seem to be in agreement that the duration plays a vital role in terms of the prognosis of a person who presents with the condition of psychosis. Moreover, traditional healers seem to place more emphasis on the causes of this condition as another determining factor for the favourable or unfavourable prognosis.
5.2.3 Traditional healers receive their knowledge from ancestors

According to the Zulu-culture, there is a continuous relationship between the living and the ‘living-dead’ (abaphansi) (Edwards, 2011). Hook et al. (2004) maintain, “the connection between the living and abaphansi (ancestors) is one of interdependence. The latter need the former to perform the rituals on their behalf. This elevates them to a significant status, thus giving them audience with God (Umvelinqangi). This means that they can then negotiate with Umvelinqangi on behalf of their descendants”. Only the persons who lived a life characterised by high moral standards can be elevated to the status of abaphansi in the Zulu culture (Hook et al., 2004).

Hook et al. (2004) define life force as energy or power that is the essence of all things, material and immaterial. Hook et al. (2004) further confirm that “life forces are frequently in interaction with one another. It is possible for unknown forces to intervene in the order of events, without people’s awareness. The nature of this intervention is beyond people’s conscious understanding. Because of this, Africans deny the possibility of events happening by chance or accident. For instance, in the event of personal tragedy, cause is sought as to how individual, the family or sinister force might have brought about the undesired results. This stems from the belief that the creative life force may be manipulated for sinister purposes. Witchcraft is one of the examples. It is commonly believed that a witch can manipulate life force to bring about an ill-fated event to someone”.

These views are in accord with what was reported by traditional healers in this study that psychosis is believed to be caused by certain people who have ill-intents about the victim. Consequently, traditional healers receive knowledge from their ancestors to know what medicine to use to heal a psychotic person. Edwards (2011) supported the view that dreams are a significant way though which abaphansi communicate with the living. Healers who participated in this study mentioned that they receive divine information from ancestors about how to heal their psychotic clients while they perform the ritual of ukuhlola, in dreams and in other telepathic ways.

5.2.4 Recovery period for people who presents with symptoms of psychosis

There was no agreement among the healers about the specific recovery period after giving traditional medicine to people who are psychotic. However, most healers agreed that it depends on the cause of the illness, and how long the person has been presenting with
symptoms of ukuhlanya. Some healers claimed that they can heal uhlanya within a few hours and some stated that it takes weeks or months. Most of the healers agreed that it depends on the individual case. This is not in concurrence with what is commonly believed in western societies, that psychosis (i.e. schizophrenia) is not a curable disorder but manageable (Sadock, & Sadock, 2010). The African belief that psychosis has a traceable cause, which is the manipulation of the life force by evildoers, makes it less questionable why African hold another complementary belief that psychosis is a reversible condition. It is logical to reason that if something is created by humans, then it can be manipulated or corrected. This is not in line with what is commonly believed in western originated mental health systems such as psychology and psychiatry that this condition, which has a biological component, is almost impossible to cure.

5.3 Limitations and implications

This research project was conducted on a few traditional healers from two closely located areas of the Zululand region. The findings of the study might not be accurately representative of the role of traditional Zulu-medicine on psychosis, because of the limited sample size from a small area. However, this research projected has succeeded in capturing the basic views of Zulu-traditional healers on the role of traditional Zulu-medicine on psychosis. The topic Traditional healers’ and caregivers’ views on the role of traditional Zulu medicine on psychosis might not have been accurately representative of the data that was gathered during the interview. For example, it emerged during the process of the study that there is not a specific thing that is referred to as a “Zulu-medicine”. This was discovered when Zulu-traditional healers mentioned that some of the herbal and animal medicines they use might have been acquired from other places outside of the area occupied by people of the Zulu cultural group and that some of the medicine might have been acquired from the sea.

In addition to that, even though there could be some medicines that most Zulu-traditional healers agree on that they are used to heal psychosis, each healer might have his/her own unique blend of plants and animal parts put together to cure one of his/her psychotic patients. This depends on the instructions from each healer’s ancestors for each individual case. Therefore, the term “Zulu-traditional medicine” might not have a specific definition that is acceptable to all Zulu-traditional healers. Perhaps, they could accept a broader explanation that it is that which is used by a healer to attempt to heal a person who presents with symptoms of ukuhlanya, in the case of this research project.
The fact that only two caregivers were interviewed in this research project calls for interpretation of the results with caution. Delving on the literature made the researcher become sceptical of the results that were obtained in this research project. For example, Niehaus, Oosthuizen, Lochner, Emsley, Jordaan, Mbanga, and Keyter (2004) discussion of amafunyana and ukuthwasa and comparing these conditions to DSM-IV-TR’s diagnosis of schizophrenia made the researcher wonder if he was investigating relatively similar phenomena but employing different words like ukuphanjanelwa yikhanda and ukuhlanya. Moreover, before commencing this study, the researcher was under the impression that the phenomenon that the researcher was investigating into which was ukuhlanya was an interchangeable term with ukuphanjanelwa yikhanda. However, during the process of the study the researcher discovered that these two concepts represent conditions that manifest with comparatively similar symptoms but caused by different things. This made the researcher slightly deviate from what was reported in Chapter 1.

It is important to note that psychosis is a broad term. There are a number of disorders that fall under this category, according to the western point of view (American Psychiatric Association, 2000). This does not seem to apply to Zulu people’s frame of reference. This is another limitation of this study. Most of the time when the researcher discussed ukuhlanya the researcher was referring to psychosis in general and schizophrenia in particular. However, the researcher avoided using the concept of “schizophrenia” in most sections of this research project because the researcher was avoiding the assumption that he already knew the “specific diagnosis” of people who once visited healers while suffering from psychosis. Also note that schizophrenia is a disorder that is diagnosable only if its symptoms have persisted for at least 6-months (American Psychiatric Association, 2000). The researcher had no evidence that people who visited caregivers had presented with the symptoms of this condition for at least this stipulated period. This is another implication of this research project. Nevertheless, this is a downfall, if you view this phenomenon through a western frame of reference. Moreover, in this study, by “psychosis” the researcher is not referring to a condition that is caused by a direct effect of a general medical condition or substance abuse. A reader might have these questions in mind when reading this project.

As mentioned earlier on, while scanning the literature the researcher’s attention was drawn into wondering if the researcher was comparing two different conditions as if they are the same condition. One needs to be sceptical of comparing two phenomena that seems to belong
to different cultural backgrounds. The researcher is under the impression that psychosis and ukuhlanya or schizophrenia is the same condition called by different names because of culture and language. As already stated, the researcher avoided using the term “schizophrenia” in most sections of this dissertation because that would imply that he has confirmed and concluded that all the people who were seeing traditional healers because of ukuhlanya were specifically suffering from this psychiatric diagnosis. Melato (2000) concurs with the researcher that this is the same condition called by different names when Melato (2000) uses the word ukuhlanya interchangeably with schizophrenia in his research project.

The different causal factors believed to be related to the illness or disorder of psychosis by traditional healers and psychologists/psychiatrist separately, might be an indication of a warning for the researcher by using the terms interchangeably as though they were one condition. On the other hand, perhaps, psychosis and ukuhlanya is a similar condition, whose conceptualisation and treatment only differs just because of the different worldviews adopted by western practitioners and Zulu-traditional healers, as the researcher assumes.

In support of the researcher’s view, when the researcher was speaking to traditional healers, both parties mutually appeared to be at the same wavelength about what they were talking about. It was evident that they were talking about ukuhlanya, which is equivalent to what psychologists and psychiatrists call psychosis in general and schizophrenia in particular. For example, one of the traditional healers mentioned that one of her grandparents suffered from ukuhlanya when the healer was still young. The healer reported that her grandparent was sent to ‘Pietermaritzburg’ (referring to Fort Napier Psychiatric hospital in Pietermaritzburg) for a ‘life-long treatment’.

The healer mentioned this event to communicate that in her opinion, western practitioners cannot cure psychosis. She added that psychosis is curable through traditional medicine. With this example, it is clear that traditional healers use of the term ukuhlanya to refer to exactly the same condition that is referred to either psychologist or psychiatrist for treatment, which these professionals call “psychosis”. On the other end of the continuum, this example gives a glimpse of what the people of the Zululand area are referring to when they use the word “ukuhlanya”. This serves to justify the researcher’s reason why he used the word ukuhlanya interchangeably with “psychosis” in general and “schizophrenia” in particular.
5.4 Recommendations

More investigation into *ukuhlanya, ukuphanjanelwa yikhanda, amafufunyana* and *ukuthwasa* needs to be done to understand these phenomena in clearer detail, in comparison to one another. More investigation into whether the symptoms that people who have had a calling to become traditional healers are called *ukuthwasa or ukuphanjanelwa yikhanda*. Conversely, is *ukuthwasa* what happens when the initiates are with qualified healers who teach them about traditional healing or is it about symptoms that these people present with? In this study, it appeared as if the symptoms are called *ukuphanjanelwa yikhanda* rather than *ukuthwasa* or *ukuhlanya*. *Ukuthwasa* is what takes place when a person is with a “teaching” sangoma. More knowledge about whether *ukuhlanya* is solely caused by bewitchment or also by refusing to accept the calling to become a healer in *Zulu* culture needs to be clarified.

More information about African’s in general and *Zulus* in particular, way of conceptualising what is termed “mental disorder” is needed for any psychologist who makes personal contact with clients from these cultural backgrounds. This is not only going to broaden psychologists’ understanding of the *Zulu* clients but will also improve the working alliance of both parties. Mental health care practitioners might be more effective in dealing with *Zulu* patients who present with symptoms of psychosis, if they have an understanding of these clients’ psychology and worldview. This would not only make mental health care practitioners become more effective, but might also make the patient feel understood which might inevitably improves the helping relationship between the two parties. Corey (2001, p. 20) maintains, “understanding your cultural background helps me establish a therapeutic working relationship. Although it is not necessary that I have to know an in-depth understanding of your culture and worldview, I must know some of your basic beliefs and values if I hope to make significant contact with you. If I am not aware of the central values that guide your behaviour and decisions, you will soon pick on this and will not likely to return for further sessions”.

5.5. Summary

In the first chapter, this research project was introduced by giving a basic definition of psychosis as a class of disorders characterised by severe distortion of reality (Feldman, 2006). The researcher then discussed the problem that he perceived in the Zululand area, which was a number of people who wander aimlessly in the streets who seem to present with symptoms of psychosis, while there are people who are known to have a reputation of healing this
condition. The researcher’s motivation to know if any of those people had visited traditional healers in the area who have a social reputation of dealing with this condition was presented. The target population of this study was 8 traditional healers, consisting of 4 from Esikhawini and another 4 from Kwa-Dlangezwa was presented. In addition to these participants, the researcher included 2 caregivers of people who once visited traditional healers while they were suffering from symptoms of psychosis. The researcher opted for a snowball sampling procedure, which was more feasible and economical for the study. It was mentioned that the data was analysed using content analysis. Limitations of the study, that its findings might not be transferrable from the Zululand area to another context because of the limited sample that participated was also mentioned.

In chapter 2, the researcher delved on the literature concerning indigenous psychology, in general, and traditional healing and medicine in particular. Here the researcher discussed a number of research articles pertaining to traditional healing and medicine as well as the under-representation of indigenous healing methods in mainstream psychology. In chapter 3, the researcher discussed the research methodology of this research project in detail which were briefly discussed in chapter 1. In chapter 4, the researcher presented the findings of this research project, which led to an identification of 4 main themes. The first theme concerned the role of traditional medicine on symptoms of psychosis. The role was reported to be to cure symptoms of psychosis. The second theme involved the view that the efficacy of traditional Zulu-medicine in healing ukuhlanya is determined by the causal factors of this condition which may differ from person to person.

The third theme involved the notion that the traditional healers’ ancestors give the traditional healers the wisdom to know what kind of medicine traditional healers ought to use to heal that particular person who presents with symptoms of ukuhlanya. The fourth theme involved the reported recovery period of people who consults traditional healers while suffering from ukuhlanya. Chapter 5 entailed the researcher’s personal discussion of the results of the study with constant comparison of these results with the already existing literature.
References


Appendix A

Consent Form

I am Siyabonga Makhanya, a student at the University of Zululand doing Masters degree in Counselling Psychology. You are being requested to participate in the study that seeks to evaluate the traditional healers’ and caregivers’ views on the role of traditional Zulu medicine on psychosis. This study is the requirement for the completion of my degree.

If you agree to participate in this study, please take note of the following before giving your consent (by signing this form).

- I understand that my participation in this study is voluntary and that I may withdraw at any stage should I feel uncomfortable.
- I understand that this study will contribute to scientific knowledge that will be used to help others.
- I understand that all information collected will be confidential.

Please fill in the following biographical data

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I have read the above information and give my consent to participate in this study.

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Signature of the participant

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Date

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Place

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