Perceptions of mental illness among the Ndebele culture, in the community of Middelburg, Mpumalanga Province

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A research report by

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ABSTRACT

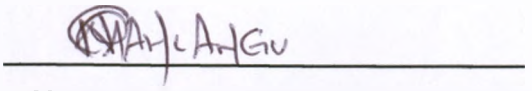
Mental illness is conceptualised differently across cultural and religious groups. How it is explained, understood, diagnosed and treated depends on how society and culture interpret it. The western way in which knowledge is generated with regards to the acknowledgement of the value of African indigenous systems of knowledge, that marginalises African systems of knowledge calls for an inclusive evaluation of such culturally-based studies. African traditional societies, such as the Ndebele, are rich in indigenous knowledge systems and can contribute to practices and social values by enhancing the enactment of understanding a community, culturally, and holistically. This stipulates that perceptions of mental illness and certain specific aspects of Ndebele cultural practice and belief systems will be explored, in relation to South African research done in this area. With this said, the area of enquiry this study is dwelling upon, is that of indigenous traditional healing, as this is strongly reflected in the findings and the discussion on the perceptions of the etiology and treatment of mental illness. This study seeks to explore perceptions of mental illness among Ndebele community members in the Mpumalanga Province and the possible role that their culture plays on their perceptions.

The study was directed at gaining an understanding of the experiences of treatment and overall exposure to mental illness within the community using the Biopsychosocial model and its extension, the Biopsychosocial-Spiritual model, as the theoretical framework. A qualitative research method was used, employing a non-probability snowball sample of 12 participants. Semi-structured interviews were conducted and analysed using interpretative phenomenological analysis. The findings of the study emphasise the importance of the Ndebele culture in day-to-day living. The themes that were found that relate to the Ndebele culture are the fact that mental illness is dealt with as a sub-culture; the causes and treatment of mental illness; and the stigma attached to people who suffer from mental illnesses. The results of mental illness among the Ndebele traditions show that mental illness is affected by cultural influences, social influences and environmental influences.

Keywords: *Biopsychosocial-Spiritual model; Culture; Mental illness; Ndebele; Stigma.*

DECLARATION

I declare that this research is my own work. It is submitted in partial fulfilment of the requirements for the degree Master of Arts in Psychology by Coursework and Research Report, a Research Report done in the Department of Psychology, University of the Witwatersrand, Johannesburg. It has not been submitted for any other research basis, paper, degree or examination at any other university or research institution.



Nonkululeko Gladness Mahlangu

Date: 2018/06/06

ACKNOWLEDGEMENTS

I firstly would like to thank my Lord God and Saviour, for granting me the courage, strength and wisdom in my overall life, especially in enabling me endurance to further my studies thus far. I would not be here today if it was not for His love, grace and mercy.

I extend my steadfast gratitude and thanks to my mentor, my supervisor, and my academic role model, Professor Sumaya Laher, for her motivation, encouragement and the potential that she saw in me.

I would like to extend thanks and appreciation to the Department of Science and Technology's National Research Foundation, DST-NRF, the institution that has groomed me, as a Graduate, whom have given me the opportunity to gain sufficient experience and research exposure for future endeavours.

I would like to thank my parents, Chief Lemmy Mahlangu and, especially my mother, Mrs. Rose Mahlangu, for her support and understanding throughout this journey towards academia.

Overall, I would like to thank the community of Middelburg, Mpumalanga, for allowing my involvement and showing interest in this study, together with my friends and family. I really am grateful.

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INTRODUCTORY CHAPTER

Mental illness has not received sufficient attention in pathology, in the discipline of Psychology, in the health sector, and in the exploration of individuals and their overall well-being. The understanding of such a discipline depends on actions, thought-processes and expectations and how these factors are considered, evaluated and accepted. A person is said to be healthy and show mental wellness when their potential is actualised, rather than blocked (Burke, 2012). This study contributes to the understanding of mental wellness by focusing on the perceptions of mental illness in the Ndebele culture. This chapter introduces the overall study and provides a summary of each chapter to follow.

Chapter 1 is the literature review that comprises an introduction of mental illness and of the Ndebele culture, followed by general perceptions of mental illness. These perceptions are followed by how the notions of mental illness are reflected in aspects of culture. This introduces the section on the Ndebele as a culture by looking at the Ndebele people and the important aspects of their Ndebele culture. The next section describes the causes of mental illness. Following the etiology of mental illness, are the various approaches to treating mental illness. The factors influencing the treatment of mental illness, which focus on the socio-economic status and health, limited health care services and stigma, are next. The section giving the study's theoretical framework and a conclusion complete the chapter. This study, as it focuses on perceptions of mental illness in the Ndebele culture, seeks to integrate the understanding, the awareness and overall interpretation of mental illness. Therefore, the Biopsychosocial model and its extension, the Biopsychosocial-Spiritual model were used as a framework of the study.

Chapter 2 is the methods chapter. It explains the aim of the study which is to explore the perceptions of mental illness in the Ndebele culture and how culture may hinder those perceptions. The background of the study stems from the lack of focus on indigenous knowledge systems, especially on issues such as marginalisation and academia, and the overall wellness of African societies, such as the Ndebele. The study used a sample of 12 participants compiled from a snowball sampling technique. A semi-structured interview

schedule with 14 questions was used to gather the data.

The qualitative research method used for the study was transcendental phenomenology. The data analysis was guided by the stages used in Interpretative Phenomenological Analysis. Ethical considerations that were taken in this study included information sheets emphasising anonymity, confidentiality and the rights of participants, which form part of the appendices. The chapter concludes with a section on self-reflexivity, which deals with any form of subjectivity or bias that may result from the researcher.

Chapter 3 presents the results of the study. This chapter begins by looking at the demographics of the participants, followed by the explication of the results and the interpretation of the overall analysis. Themes such as the cultural importance in the Ndebele community emerged. The main finding of the study is the importance of aspects of the Ndebele culture, such as language, competence and performance. The other main findings are abnormal behaviour, causes of mental illness, treatment of mental illness and stigma.

Chapter 4 of the study is the discussion of the results. This chapter looks at content-based results, which are the cultural importance in the Ndebele community, the notions of abnormal behaviour, the causes and treatment of mental health issues, witchcraft, punishment and traditional healing. It concludes with a discussion of stigma and the affordability of treatment.

Chapter 5 presents the limitations and recommendations and conclusions of the study. This is a summary of the overall Ndebele culture, the Ndebele cultural perceptions on mental illness, limitations with regard to interviews, interest and participation of the study and the influence of the researcher's knowledge of the concept of mental illness and psychology.

CHAPTER 1: LITERATURE REVIEW

1.1. Introduction

Mental illness is a serious phenomenon which can impact anyone. According to Madzhie, Mashamba and Takalani (2014), about 1% of humans develop mental illness in their lifetime. Furthermore, according to the World Health Organization statistics, 450 million people worldwide are affected by mental, neurological or behavioural problems (Mehraby, 2009). Scheider, Docrat, Onah, Tomlinson, Baron and Honikman et al. (2016) report that according to the Department of Health, in regards to South Africa, one out of four people have, or is affected by mental illness and between 1% and 3% of the population is likely to suffer from a mental health problem, leading to hospital admission. Furthermore, one in six South Africans present with depression, anxiety or substance use disorders (Skeen & Lund, n.d.). A prevalence of 30,3% for depression and anxiety disorders, in a lifetime spectrum, was visible in the population of South African adults. In South Africa, according to Schneider et al. (2016), mental illness often occurs simultaneously with what is known as the "quadruple burden of disease" (p. 158), namely, maternal and child illnesses, infectious diseases such as HIV and TB, injury and non-communicable diseases such as diabetes. These are reported by looking at the prevalence of mental disorders amongst these groups of diseases (Gray & Vawda, 2016). There are clear conceptions of mental illness which are influenced by biological factors, environmental factors and many other day-to-day stressors (Schnittker, Freese, & Powell, 2000). These lead to the overall focus of this study.

According to Myers (2008), culture is defined as the enduring behaviours, ideas, attitudes and traditions, shared by a large group of people that are transmitted from one generation to the next. Each culture has its own beliefs about illnesses, including mental illness (Nkosi, 2012). However, in Africa and South Africa, the understanding of the interaction between cultural beliefs and illness is not researched sufficiently. Hence, the focus of this study was to explore how culture, tradition and behaviour may influence perceptions of mental illness in the Ndebele culture.

This literature review will, firstly, present the currently accepted definition of mental illness

in mainstream psychology as well as critiques of this definition based on cross-cultural understandings of health and illness. Following this, the literature review provides a contextual background of the Ndebele culture in terms of its origins, background and customs. Literature based on the understanding of mental illness in the Ndebele culture, what are seen as the causes of mental illness and how mental illness is treated is then presented.

1.2. Perceptions of mental illness

Mental illness is conceptualised differently across cultural and religious groups (Sehoana & Laher, 2015). The explanation of illness and disease also varies depending on culture, society and individuals (Nkosi, 2012). According to Mufamadi and Sodi (2010), Western psychological theories mainly understand mental illness to be some form of deviant behaviour. In the field of social sciences and psychology, a mental illness is perceived through a diagnosis, based on a clinician's professional understanding of the patient's thoughts and feelings. This diagnosis is then cross-referenced to a diagnostic manual, called the Diagnostic and Statistical Manual of Mental Disorders – Fifth Edition (DSM-5, 2013), together with the International Statistical Classification of Diseases and Related Health Problems (ICD 10, 2016) (Sadock, Sadock, & Ruiz, 2015). According to the DSM 5 (2013), mental illness is understood as follows:

> "A mental disorder is an intellectual disability; a behavioural or psychological syndrome or pattern that occurs in an individual; the consequences of which are clinically significant distress or disability; must not be merely an expectable response to common stressors and losses; and is not solely a result of social deviance or conflicts with society ..." (DSM-5, 2013: 25).

The World Health Organization (2016) state that, according to the ICD 10, a mental disorder implies the existence of observed clinical symptoms and behaviours that relate to distress and interfere with a person's normal functions. In this study, a mental disorder and a mental illness will be utilised interchangeably, as there is no fundamental difference between mental illnesses and disorders as they both are subsets of a general disorder or illness, in this case, subsets of mental health (Burke, 2012). The recently revised DSM explains that patients present symptoms, that those symptoms can be categorised, and

implicitly, that the sane are distinguishable from the insane (Rosenhan, 2016). The psychological definition of mental health focuses on the individual's experience of vitality and his/her habitual behaviour. Each person must take responsibility for gathering knowledge about his/her health and for performing adequate healthy behaviour in his/her daily life (Egger, 2013). Furthermore, in other spheres of daily life, apart from the psychological, mental health is also required to be holistic and genuine, in that it must include the overall person's life, by looking at the physical, psychological, social and the spiritual spheres of their lives (Beng, 2004). This may further assist in the knowledge base and understanding of mental health.

As societies vary extensively regarding culture, homesteads and an overall way of living, explanations of the perceptions of these societies need to be understood. Mental health care and mental illness, in this instance, should take into account the variations mentioned above (Mowbray & Holter, 2002; Peltzer, 1999) that is based on diverse levels of language, ethnicity, race and religion. However, the diversification comes with problems and challenges to the society's functioning, and the functioning of the health care system (Gray & Vawda, 2016). When considering the variations, the perspective of mental illness in cultural aspects will be introduced, as they may vary or be similar, similar to normal, ordinary, academic and health defined perceptions of mental illness.

1.3. Etiology of mental illness

The World Health Organization (WHO, 2016) states that, "there is no health without mental health" (p. 153). This statement emphasises the importance of mental health as a part of general health (Gray & Vawda, 2016). Labelling mental illness as a mental health problem results in a better understanding of the nature of the issue (Angermeyer & Matschinger, 2003). Illness and disease are characterised by their own distinctive pattern of symptoms and natural history (Prince, 1985). In many non-western cultures where psychological problems are stigmatising and sufferers risk being labelled as 'mad', psychological distress is often expressed through somatic complaints such as headaches, backaches and stomach aches (Mehraby, 2009). Mental disorders further result in lower life expectancy and increased risk of co-morbid physical illness and often result in limited access to proper and sufficient general health care services (Gray &

Vawda, 2016). People with physical diseases or illnesses therefore are more prone to common mental disorders than people who are physically fit and well.

In the West, mental illnesses, such as depression, are said to be caused by the environment, specifically by day-to-day stressors (Jorm, 2000). In addition, the western theories believe that mental illness may be caused by a person's inner psychic disturbances whereas, in non-western cultures, mentally ill persons show behavioural signs and symptoms that do not fit in with the traditional norms of the society (Mufamadi & Sodi, 2010).

Further etiologies of mental illness have been identified, not only in its tangible physical manifestations. These etiologies elaborate on culture-based knowledge, beliefs and practices. Beliefs and practices which are traditional, and concerning illness and health, are still largely evident, more especially in the semi-rural and rural places of South Africa (Burke, 2012) and are not only physical but also traditional, culture bound and spiritual:

> "The most commonly cited cause of mental illness was misuse of drugs, followed by traumatic life events, misuse of alcohol, stress, and genetic inheritance, also witchcraft, possession by evil spirits and punishment from God were endorsed as possible causes" (Ukpong & Abasiubong, 2010, p.15).

Nkosi (2012) elaborates on the causes mentioned in the latter quotation by stating that the factors contributing to mental illness are put under spectrums of darkness and/or light. The darkness includes witchcraft or punishment as a result of being disobedient to the spiritual forces, both ancestral and the spirit of light, which is Christianity. Some individuals view mental illness in religious terms and believe that any disorder of the mind reflects and assimilates the will and plan of God, or any other greater power (Schnittker et al., 2000). Ndlovu-Gatsheni (2005) supports this by stating that the most common causes of mental disorders are the anger of *amadlozi* (ancestors), witchcraft and possession (Jorm, 2000; Ndlovu-Gatsheni, 2005).

According to epidemiologists, who study branches of medicines dealing with the incidence, distribution and possible control of diseases, life events and stressors are more of a trigger than an etiology (Jorm, 2000) which may lead to mental illness.

Disciplines such as sociology, psychology and psychiatry study etiological beliefs to understand people's perceptions, the ways that they construct their world and explain social issues such as environmental problems (Schnittker et al., 2000). Therefore, it is important to examine individual and communal beliefs, attitudes and behaviours regarding mental illness.

1.4. Cultural aspects of notions of mental illness

According to Pillay, Ahmed and Bawa (2013), mental health resources in South Africa are distorted, biased and insufficient. Mkhize and Kometsi (2008) emphasize that such health resources, in relation to mental well-being, is said to not just be the absence of a psychiatric condition, but it also involves physical, social, cultural and spiritual aspects of life that are morally and traditionally understood and defined (Nkosi, 2012). In order to understand a community, how it is affected by mental illness, and how its beliefs affect the mentally ill, it is necessary to understand its way of life. Kabir, Iliyasu, Abubakar and Aliyu (2004) further state that recognising the mentally ill depends on carefully evaluating the norms and beliefs within the individual's cultural environment. This is supported by Fallot (2001) who states that an individual's cultural context influences the actual content of symptoms, such as delusions and hallucinations. In addition, western medicine and mental well-being, both now and in the past, harbours many popular descriptions and illustrations for illnesses, and cultural and social factors are generally thought to influence the frequency of disease rather than the syndromes themselves (Prince, 1985).

This cultural aspect to illness, such as mental illness in relation to the individual's culture, social setting and overall environment, is called a Culture-Bound Syndrome. It is defined as a collection of signs and symptoms which are not found universally in human populations, but are restricted and unique to a particular culture, group or society (Sumathipala, Siribaddana, & Bhugra, 2004; Prince, 1985). What is viewed as normal in one culture may be seen as quite divergent in another, thus notions of normality and abnormality may not be quite as accurate as people believe they are (Rosenhan, 2016).

Although there are distinct differences that pertain to the existence of cultural views in mental illness, historically, mental illness in most cultures, including some western cultures, has been viewed in a religious and spiritual context (Mehraby, 2009). According

to Latzer (2003), a culture provides a certain worldview, which explains a certain world and its surrounding forces, finding expression, in this instance, in diseases such as mental disorders. These include that mental illness is a punishment, caused by misconduct of the family or by the ancestors (Wong, Pui, Pearson, Chen, & Chiu, 2003) while insanity is caused by sorcery, failure to do certain rituals, the devil's eye or possession (Parle, 2003; Mehraby, 2009). Additionally, some might even view mental illness as a religious wakening or a holy message communicated from God, thereby linking it with a higher, greater spirit (Mehraby, 2009). In order to adequately understand and treat the affected and effected therefore it is necessary to ascertain the mental health norms apparent in the culture (Latzer, 2003). This study looked at mental illness in the Ndebele culture by investigating its way of life and worldview, and how these may contribute to the knowledge of mental illness.

1.5. Who are the Ndebele people?

It is not clear where the name 'Ndebele' and the overall culture came from (Matjhiga, 2006; Mabena, 1999). Khumalo (2005) states that the Sotho called all raiding Nguni groups *kiMatebele*, meaning warriors with long shields, which is thought to be the origin of the name Ndebele. However, the name *Matebele*, meaning 'stranger', has been applied to other Nguni speaking people (Swazi, Xhosa, Zulu) apart from the Ndebele (Mazarire, 2003).

In the history of the amaNdebele people, two sons, Ndzundza and Manala, fought for leadership that caused the amaNdebele to be divided as a nation (Matjhiga, 2006) into the Southern and Northern amaNdebele. The northern groups, which are called the *Manala*, moved to Mokopane and Polokwane at the beginning of the nineteenth century. The southern group, comprising the *Ndzundza* (Van Vuuren, 1991), live near Tshwane and Mpumalanga, near Bronkhorstpruit, Middelburg and Belfast. Delius and Hay, (2009) and Skhosana (2010) explain that the cultural heartland of the Ndebele people is located in the north-west part of Mpumalanga along the border with Limpopo and Gauteng. For the purpose of this study, the focus will be on the southern group of amaNdebele (Matjhiga, 2006), found in numerous towns such as Stoffberg, Middelburg, Belfast, Bethal and Carolina in Mpumalanga Province.

The map represented in Figure 1.1 below shows the Mpumalanga province and surrounding areas.

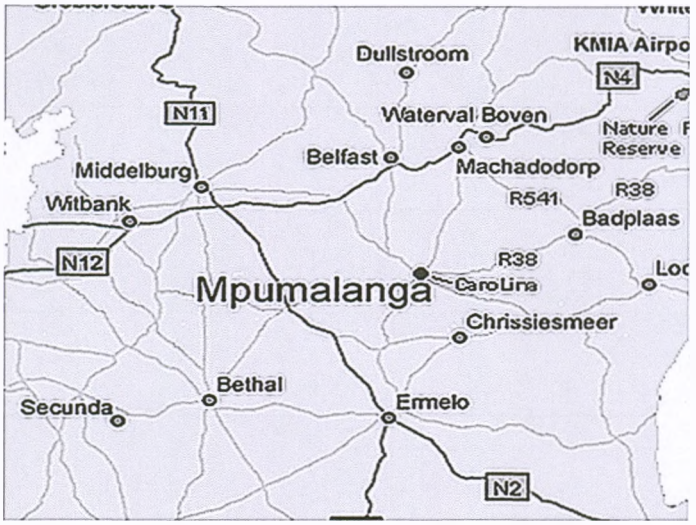

Figure 1.1. **Mpumalanga Map (Areas of focus)**

IsiNdebele is the language of the Southern amaNdebele, and is part of the Nguni group of languages, containing different click sounds, that also draw from both English and Afrikaans (Matjhiga, 2006; Khumalo, 2005). Afrikaans words have also become part of the language, dating back to the time when the Ndebele people worked on the farms of Afrikaans-speaking farmers. An example of this is an Afrikaans word (trekker), the word for 'tractor' which is 'iterekere' and now part of the Southern isiNdebele language. One can tell from the spelling and pronunciation that it is derived from the Afrikaans word.

The Ndebele call their culture *isikhethu*, (which literally means "that which is ours") (Hofmeyr, 1993) and it is of utmost importance for Ndebele people to follow and abide by *isikhethu* (Huffman, 2004, p. 88). *Isikhethu* comprises strong patriarchal attitudes and practices that have been retained even though the women have come to be thought of as the custodians of *isikhethu,* consisting of the relationships, beliefs and practices on which the crucial Ndebele identity is centred (Hofmeyr, 1993; Van Vuuren, 1991).

Traditional amaNdebele homes were beehive-shaped buildings made from young trees, called saplings, and thatch but today their homes are rectangular buildings with corrugated iron roofs. Cooking is normally done outside in a courtyard over an open fire.

It is thought that the art of the amaNdebele people began as decorations and patterns on the mud floors of homes. It is mainly women and girls who are responsible for decorating the walls with their multi-coloured murals (Matjhiga, 2006), providing some Ndebele women with an independent lifestyle in making a living with this skill (Hofmeyr, 1993).

IsiNdebele has not received as much attention in research compared to the Zulu and Sotho languages. This may be because the Ndebele language is still regarded as a dialect of the Zulu (Mashiyane, 2002) as it demonstrates significant similarities with the characteristics of the Nguni ethnic group (Skhosana, 2009). Also, the Ndebele history currently recorded is not clear and is often contradictory (Ndlovu-Gatsheni, n.d.). Therefore, what is known regarding the Ndebele culture is by word-of-mouth, and the elders' knowledge is an attempt to express themselves, identify themselves and set themselves apart from other ethnic groups (Ngoma-Leslie, 2004).

1.6. Important aspects of the Ndebele culture

The amaNdebele way of life comprises specific obligations. The Ndzundza men, especially those from a background of chieftaincy, still practice polygamy (Hofmeyr, 1993). Van Vuuren (1991) states that brides must always practice *ukuhlonipha*, "respect" for their husbands, fathers-in-law and any male in the family which includes physical avoidance and first name taboos. Ndebele, being a member of the Nguni, shares components with the other Nguni such as the use of language and ceremonies (Mashiyane, 2002). These components, which are important aspects of the Ndebele culture, include rites of passage such as the practice of circumcision that symbolises *ukuwela*, "to cross over the river" for boys, and *ukuthomba* "to reach the age of puberty" for girls (Skhosana, 2010; Khumalo, 2005; Ndlovu-Gatsheni, n.d.).

> "The male initiation, *ingoma or ukuwela*, which includes circumcision, is a collective and quadrennial ritual that lasts 2 to 3 months during the winter (April to July). Through this process, young boys are inducted into the deep mysteries of the group, where the initiates in the post-liminal stage, receive a regimental name from the paramount, and it is the name with which a Ndebele man identifies himself for life. The ritual is controlled, installed, officiated and administered by the royal house" (Nyathi, 2001: p.34).

The rite of passage, or initiation, dominates ritual life in a Ndebele society. The girls' rite of passage is as follows;

> "*Iqhude or ukuthomba*, is organized on an individual basis within the girls' homestead. It entails the isolation of a girl after her second or third menstruation in an existing house in the homestead, prepared by her mother. The weeklong isolation (*ukuphathela)* ends over the weekend, when as many as 200 relatives, friends and neighbours attend the coming-out ritual. The occasion is marked by slaughtering cows and goats, cooking and drinking traditional beer, song and dance, and the large-scale presentation of gifts to and from the initiate's mother" (Van Vuuren, 1991: p.21).

After initiation, the young people are seen as adults and the Ndebele culture celebrates marriage. According to Matjhiga (2006), initiation, marriage, family, traditional beliefs, music and dance, and food play a special role in the social, family, spiritual and physical life because it is believed that the ancestors protect them, give them strength and growth in living during these important aspects (Huffman, 2004).

1.6.1. Understanding mental illness in the cultural (Ndebele) perspective

The notion that indigenous knowledge is distorted in South Africa extends to the access of Ndebele literature, proving the remaining challenges in African indigenous knowledge systems, and the mental health divisions. In understanding mental illness in the Ndebele perspective, one absorbs from the latter information on the notions of mental illness in cultural aspects. The Ndebele are renowned for their art and culture, especially their paintings and colour coordination. Therefore, understanding mental illness requires a focus on both the art and the theories that conceptualize the overall culture. According to Magid (2011), the main features of fully understanding indigenous systems, is to include all aspects of life, in a community-based manner and in written, preserved oral tradition, practices, customs, oral stories and the rituals. What this brings is that the perspective of the Ndebele may be seen in their natural spheres, their day to day living and their cultural domains.

The Ndebele people are said to be religious people, who struggle to distinguish between their culture and African traditional religion (Moyo, 2013). In African traditions, it is said there are a variety of reasons for mental illness, and the causes of mental illness. "In

Zimbabwe, a person is considered mentally ill if he or she performs foolish acts without realizing what he or she is doing" (Chavunduka, 1994:11). In addition, Sorsdahl, Flisher, Wilson and Stein (2010) mention that people are generally able to identify mentally ill patients based on behaviours such as smearing or eating faeces or laughing at inappropriate times, such as when a person is dying. Normality, and presumably abnormality, is distinct enough in that it can be recognised wherever it occurs, or is carried within the person (Rosenhan, 2016). However, for the Ndebele specifically, it is difficult to pick out behavioural patterns which a Ndebele person can then say is culture, and the other is religion (Moyo, 2013). Therefore, what this emphasizes is the Ndebele cultures' challenge of not being able to distinguish between African cultural perspectives and their perspective. For instance, what was believed was that the Ndebele painted colours, has sacred powers and are the reason to be called by the ancestors, and if the colours are destroyed by rains, the ancestors are symbolizing their anger and disregard (Ngoma Leslie, 2004). With the notions of mental illness and cultural aspects in mind, this shows clearly that the perspective of the Ndebele does not distinguish a great deal, but it does vary in regards to their cultural patterns and the art, therefore ancestors, symbolism and tradition play a role in the influence of mental illness in the Ndebele culture.

1.7. Variety of approaches to the treatment of mental illness

Mental health services play a role in a variety of treatment areas (Kirmayer, 2012). Ways of understanding and curing illness are different, depending on the culture but, generally, several types of treatment that complement each other may be used (Nkosi, 2012). However, many people are not able to recognise and fully comprehend mental disorders and the psychological and psychiatric terms that describe them (Jorm, 2000). Culture-bound syndromes, when looking at the Western diagnostic systems contexts, show that there are links between cultural beliefs, environmental stressors and symptoms which are often ignored (Sumathipala et al., 2004) because "there is good evidence that culture, language, ethnicity, and religion influence the causes, manifestations, and course of mental disorders" (Kirmayer, 2012: 251). According to a study by Pillay et al. (2013), around 77,5% of participants knew of no person in their community who had consulted, or was consulting a psychologist because, although the hospitals do provide psychiatric care, no counselling services were available. Sufferers of mental illness are therefore

often cared for at home by their families rather than being sent to mental institutions (Mehraby, 2009).

The difference between modern and traditional aspects of medicine is obvious especially when looking at the individual and the community's beliefs, attitudes and practices (Edwards, 1986). There are various treatment approaches to mental illness, including religious treatment. There are individuals who believe that mental illness is caused by biological factors and/or environmental causes and that treating mental illness to reach recovery, requires prayer and a strong covenant with the church (Schnittker et al., 2000). Spirituality, prayer and meditation also have beneficial characteristics for mental illness by giving meaning and a purpose to life (Hatala, 2013). This means that the affected and the effected persons should be strong in their religious livelihoods, and definitely recovery will happen, because mental illness and any disorder of the mind, is a reflection of what God is seeking. Modernisation is focused upon medicine and the health sectors, adopting views of traditional and modern medicine. In South Africa, according to Edwards (1986), there are both modern and indigenous ways of treating mental illness. Indigenous treatment procedures are followed and practiced especially in the rural areas by:

I. *Inyanga* – "Inyanga is a traditional doctor, who is usually male, and specialises in herbal medicine".
II. *Isangoma* – "Isangoma is called the diviner, who is traditionally female, and operates within a traditional religious supernatural context as an accepted medium with the ancestral shades and the faith healer".
III. *Umthandazi or Umprofethi* – "Umthandazi or Umprofethi is a faith healer that can be traced to the rise of the African independent church movement" (Edwards, 1986: 1273).

Traditional Africans believe that a health problem, especially one that is of mental health, comes from a disconnection or an issue that relates to the connection between the mentally ill person and the gods, other people or the ancestors. Therefore, traditional healers' recovery processes include the families, the gods and the ancestors, together with the patient (Burke, 2012). Africans normally consult traditional healers rather than the more scientifically-based Western medical services, according to Sorsdahl et al.

(2010), but this may be due to a lack of access to the western services in many parts of Africa. Africans, though, believe in the healing process of consulting traditional healers, because they are accessible, they form part of the same traditional beliefs of the community and are believed to be qualified to heal (Burke, 2012).

Perceptions that are held in communities play a role in the treatment sought and how these treatments are viewed (Sehoana & Laher, 2015). For example, the patients who see a health practitioner have their own beliefs regarding health that may be based on religious and indigenous beliefs and practices (Gray & Vawda, 2016) that may be incorrect for the treatment of mental illness. Therefore, patients would go to a health practitioner because of the domination of western systems, especially those of medicine, and the hurdles and challenges that may be faced when alternating to a sangoma for instance.

As far as mental health is concerned, Mkhize and Kometsi (2008) show that patients' concerns may exceed traditional psychological concerns and include concerns about housing, job security and disability benefits. However, Nkosi (2012) notes that people may opt to use more than one treatment procedure as they believe that traditional treatment is able to complement western treatment. In Africa, and South Africa, there is acceptance of the combination of treatments involving modern methods and traditional methods which needs further investigation (Edwards, 1986), as Nkosi (2012) confirms:

> "The treatment of mental illness uses a variety of traditional medicine while Western medicine on the other hand is considered a second option ... A variety of *izimbiza* is the most used traditional medicine in a form of a liquid, *imbiza* is a mixture of different herbs that are put together, depending on the nature of the disease or illness that it has to treat".

This manner of treatment, as quoted above, shows the accessibility of traditional healers and favours the unemployed and the poor, because western treatments are difficult to access and may be expensive (Burke, 2012).

1.8. Factors influencing the treatment of mental illness

The causes, clinical views, prognosis, and treatment options for common mental

disorders are not commonly known by the community (Todor, 2013). Socio-economic status, limited health care services and stigma hinder treatment of mental illnesses. This gap needs to be addressed (Gray & Vawda, 2016). My study shows that such gaps may be influenced by socio-economic statuses, culture, tradition and the overall state of the communities. What the overall state of the communities means, is the depth of their day to day livelihoods, from how they go by on a daily basis, reaching to the knowledge sources which prove complementary to the society, or prove to hinder the society. This day to day living may be the challenge that hinders treatment, because of routine activities and the fear of change, or the overall lack of sources which may contribute to the betterment of the communities.

1.8.1. Socio-economics versus Health

The incidence of mental disorders is relatively high in South Africa, as the 2003 South African Stress and Health (SASH) study delineates, where prevalence in mental disorders was 16,5% in relation to a 12-month ratio, and a prevalence of a lifetime diagnosis of a mental disorder of 30,3% in the adult population (Gray & Vawda, 2016). It also reported that about 75% of mentally ill people do not receive any form of service or mental health treatment (Gray & Vawda, 2016: 154; Burke, 2012). This may be due to factors such as unemployment, poor housing and poverty that affect mental illness and the stigma of seeking treatment (Kakuma, Kleintjies, Lund, Drew, Green, Flisher, & MHaPP, 2010). With educational and socio-economic disadvantages in poorer countries, an absence of information and ignorance towards mental health issues causes stigma that has to be overcome to encourage overall well-being (Pillay et al., 2013). A strong correlation exists between poverty and mental health, where mental disorders have been proven to be common amongst the poor, in which, for instance, unemployment and poor social welfare conditions could lead to anger, despair and a loss of hope (Mkhize & Kometsi, 2008; Neille, 2013). This means that the public needs to have knowledge and understanding of mental health, because the prevalence of mental disorders is up to 50% of the whole population, so that almost everyone may develop a mental disability, or be affected closely by it, be they family, neighbours or colleagues (Jorm, 2000). In addition, psychiatric diagnoses may portray little about the patient but much more about the environment in which an observer, in this instance, a psychologist, psychiatrist or

therapist, finds the patient (Rosenhan, 2016). Therefore, cultural perspectives of mental illness vary among individuals, families, ethnicities and traditions and often influence beliefs about the origins and nature of mental illness and shape overall attitudes towards the mentally ill.

1.8.2. Limited health-care services

Compared to other branches in health sectors, the mental health sector remains small in most low and middle-income countries, South African included. Some of the difficulties and concerns that have been seen in South African communities are, according to Mkhize and Kometsi (2008, p. 9), "limited resources, the lack of availability of care at community levels, the potential of family neglect and other concerns such as culture and education". Today, there are more available health care options in South Africa than in the past (Sorsdahl et al., 2010), however, the difficulties arising to treatment and seeking help, dominate excessively. These include the lack of access to mental health care services due to distance, stigma and discrimination faced by mentally ill individuals which hinders them from seeking mental health care (Kakuma et al., 2010). Roberts, Robinson, Topp and Newman (2008) mention that, although there may be health care facilities, only two thirds of persons with a known mental disorder will seek professional help and that 75% of such persons do not receive it because of limited health-care services. Therefore, the health care options are still not enough, especially for people with a low socioeconomic status.

1.8.3. Stigma

Many research findings have confirmed that, globally, people have negative attitudes towards the mentally ill (Link, Yang, Phelan & Collins, 2004) and communities' poor knowledge of mental disorders have caused stigmatising attitudes (Ukpong & Abasiubong, 2010). The statistics mentioned in this study show that mental illness causes stigma, isolation and social rejection (Todor, 2013).

This stigma not only occurs in the communities, but also at social, economic, psychological and professional levels (Kakuma et al., 2010). According to Egbe, Brooke-Sumner, Kathree, Selohilwe, Thornicroft and Peterson (2014), these problems impede the self-esteem of the mentally ill who face marginalisation, social isolation, anxiety, poor

social skills, difficulties in securing employment, housing difficulties and poor social support (p. 1) that are necessary for the proper functioning of society. Stigma is defined as "a sign of disgrace or discredit that sets a person apart from others, relating to context than to a person's appearance" (p. 65), either discrediting, meaning it is obvious to others, or discreditable, which is not obvious to others (Byrne, 2000; Dinosa, Stevens, Serfaty, Weich, & King, 2004). Stigma, as a social construct, defines people in terms of distinguishing characteristics or marks and devalues them as a result (Dinosa et al., 2004). Stigma may be visible or invisible, and have long term consequences, not only for the mentally ill person, but also for the person's family and community (Nxumalo & Mchunu, 2017).

Stigma relates to knowing, a refusal to acknowledge, and attitudes which are prejudicial (Egbe et al., 2014). Stigmatising of people with mental illness is seen as a societal problem. It is caused by fears of the community regarding the mentally ill (Nxumalo & Mchunu, 2017). "The public opinions about mentally ill patients significantly affect their self-concept, their willingness to seek professional help, the evolution of the illness, and their opportunities for social integration" (Todor, 2013: 211). Stigma, where the mentally ill are singled out in an unjust manner because of their mental or physical state plays a major role in the suffering associated with mental illness (Kakuma et al., 2010).

There is a general consensus in the literature that, in most cultures, mental illness brings shame and stigma for both the sufferers and their families (Mehraby, 2009) as mentally ill people are viewed as irresponsible, unable to control themselves, incurable, irremediably lost to the society, dangerous or living in their own mysterious worlds (Todor, 2013: 210). Mentally ill individuals and those affected face stereotypes which hinders attempts to understand mental illness and seeking treatment. Stigma can pose a challenge to one's humanity and is personally, interpersonally and socially costly (Dinosa et al., 2004). Stigma prevents mentally ill persons from recovering by gradually destroying their self-esteem, self-image and self-worth, which ultimately affects the treatment plan and the compliance with treatment (Nxumalo & Mchunu, 2017).

Because persons with mental illness battle with stigma, discrimination and negative stereotypes, places that these individuals seek help from, be they health facilities, clinics,

hospitals or private practices, must be non-judgmental and value free (Egbe et al., 2014). The studies mentioned above point out that if the public familiarises themselves with mental illness, by being in contact with the mentally ill, then stigma towards the mentally ill might lessen (Todor, 2013).

1.9. Theoretical Framework: Biopsychosocial Model and the extension to Biopsychosocial-Spiritual Model

The theoretical framework informing this study is the Biopsychosocial (BPS) model, and its extension, the Biopsychosocial-Spiritual (BPS-S) model. It is used to understand the biological, social, psychological and spiritual factors influencing illness as discussed below. This is because religion and spirituality play a particular role in people's lives including those diagnosed with a mental illness (Fallot, 2001).

The phenomenon of mental illness and the Ndebele culture have been reviewed, and the descriptions of the aims need to be evaluated, which are the exploration of mental illness in the Ndebele culture, and how culture may influence these perceptions.

The BPS model is a modern humanistic and holistic view of the human being that recognises that the biological, psychological and social levels of an individual's life need to be attended to simultaneously in order to understand and treat a patient (Saad, de Medeiros & Mosini, 2017). The Biopsychosocial model states that the body, mind and the environment all affect each another, meaning that the interrelation of these three components account for biological, psychological and sociologically interconnected spectra as systems of the body (Boundless, 2016; Lakhan, 2006).

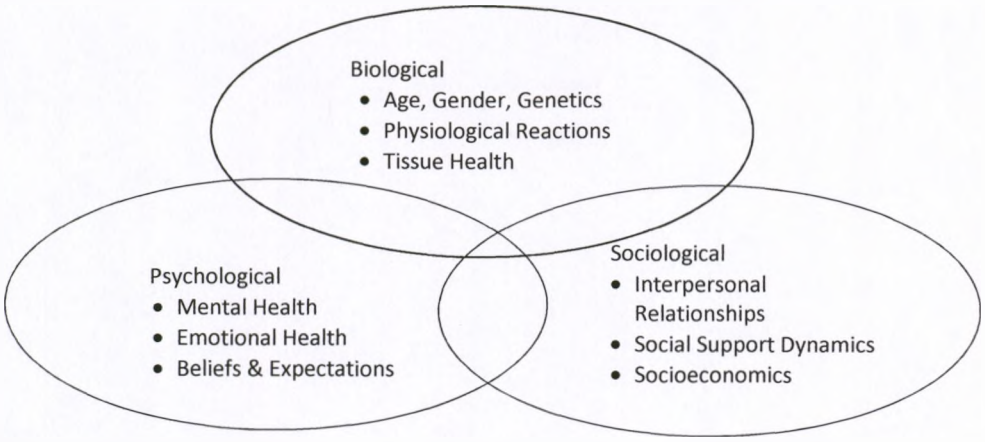

Figure 1. 2. Biopsychosocial Model Interconnection

A notion of the BPS model of health and illness is one which intertwines the patients' psychological, social and cultural spheres into a framework that holistically understands health, disease and illness (Hatala, 2013) where the concept of wellness is particularly stressed and where the state of being in good health, based on this model, is accompanied by a good quality of life and strong relationships (Lakhan, 2006). Health within the Biopsychosocial model is defined as "the sufficient competence of a person to cope through self-regulation with any stressful disturbance on every system level. Health is not the result of absent pathogens ... and means not the absence of psychological stress or conflicts, but the ability or to control those potentially pathogenic factors sufficiently" (Egger, 2013).

Saad et al. (2017: 1) describe the BPS model:

> "The biopsychosocial model is both a philosophy of clinical care and a practical clinical guide. Philosophically, it is a way of understanding how suffering, disease, and illness are affected by multiple levels of organization, from the societal to the molecular. At the practical level, it is a way of understanding the patients' subjective experience as an essential contributor to accurate diagnosis, health outcomes, and human care."

Mental illness, as a psychological impairment, as described by the quote above, can therefore be described as the mind in this model, where the body shows the effects it has, such as the behaviours and clinical distresses. However, the environmental factors, like patient care, receive the attention (Sulmasy, 2002). In the case of culture, the mind, body

or environment forms a component, hence, the extension of the BPS model which is the Biopsychosocial-Spiritual (BPS-S) model. The BPS-S model looks at the biological, the psychological, the social, and the spiritual, as distinct dimensions of the person that are integrated to form the whole person (Sulmasy, 2002). Culture, spirituality and beliefs refer to how individuals express themselves inclusive of nature and religious practices (Sulmasy, 2002). The model accompanies a shift in focus from disease to health, recognising that psychosocial factors, such as beliefs, relationships or stress, impact on the recuperation from illness and disease (Lakhan, 2006). The expansion of the BPS model to the BPS-S model addresses the totality of the person's holistic healthcare, as a humanistic model that seeks to account for all levels of one's life (Saad et al., 2017). Therefore, the use of these models will lead to an understanding of mental illness as a psychiatric health problem by linking them to the Ndebele culture and showing that these components are not limited to one specific human experience, but as simultaneous phenomena.

1.10. Conclusion

This study explores the Ndebele culture and its perceptions of mental illness. This literature review dwells extensively on this phenomenon by looking at the Ndebele people, the important aspects of the culture, perceptions and notions of mental illness, beliefs about what causes mental illness, and the various strategies used to treat it.

Community members play an important role in the conservation, or rehabilitation of individuals' well-being in the whole community especially to those who are mentally ill and those affected by this. These communities, especially indigenous communities, can be said to be epistemic cultures, which means that they are grounded on knowledge because they focus on the important aspects of the self and their identity as a whole, their belonging, and their special, unique values that are based on this form of knowledge (Kirmayer, 2012). Therefore, this study explored community members' notions of mental illness, and how important is it to look at a healthy lifestyle that considers a holistic approach to mental health. The reason for this is that, in treatment and rehabilitation programs in the field of psychiatry, reaching a diagnosis utilising the DSM involves the assessment of the individual, family, culture and religious experiences (Fallot, 2001).

Therefore, a holistic approach to study is necessary as it includes the cultural aspects of mental illness.

CHAPTER 2: METHODS

This chapter outlines the methods, the aim, the rationale, research questions, the sample, instruments, design, procedure, data analysis and the ethical considerations of this study.

2.1. Aim of the study

The aim of the study is to explore perceptions of mental illness among members of the Ndebele culture, in Middelburg, Mpumalanga Province, and how culture may influence these perceptions.

2.2. Rationale of the study

Ngobe (2015) notes that diseases and illnesses are common to all societies. However, the types of diseases that occur and the ways in which they are diagnosed and treated depend on how people interpret them and this varies from one society to the next. Similarly, the methods considered acceptable for curing illness vary and a way of understanding and curing illness in one culture may not be acceptable in another (Nkosi, 2012). It is necessary to understand fully how a society perceives mental illness in order to address and treat it effectively. Kabir et al. (2004) further state that knowledge of the attitudes towards mental illness and an awareness of the beliefs regarding mental illness and its treatment are important to realise the growth of a community. Mental illness should be understood and studied holistically because, according to Magid (2011), the western phenomenon of knowledge and the marginalisation of African systems of knowledge continue to pose a problem in academia that calls for a comprehensive evaluation of such studies. African traditional societies, such as the Ndebele, are rich in indigenous knowledge systems that can contribute to social values and practices by enhancing the understanding of a community, culturally and holistically (Moyo, 2013). The main challenge that still remains is "for indigenous scholarship to begin to explore the theoretical frameworks that are African indigenous" (Mkabela & Castiana, 2011: 6). In addition, virtually all research on this topic is afflicted by shortcomings of methodology (Schnittker et al., 2000), hence the exploration of indigenous studies.

Therefore, with these issues in mind, this study sought to explore perceptions of mental illness among Ndebele community members in the Mpumalanga Province and the

possible role their culture plays on their perceptions. It was also directed at gaining an understanding of the experiences with regards to treatment and overall exposure of mental illness within the community, and the area of enquiry was that of indigenous traditional healing, which reflected phenomenal findings on the perceptions of the causes and the treatment of mental illness.

2.3. Research Questions

1) What are perceptions of mental illness from the point of view of members of the Ndebele community?

2) How are their perceptions of mental illness influenced by their culture?

2.4. Sample

A non-probability snowball sampling technique was used for this study. Snowball sampling refers to the process of accumulating participants suggested by others. This is done by collecting data on a few members of the target population who are asked to provide information needed to locate other members of that population, whom they happen to know (Babbie & Mouton, 2001:167). Hence, this technique was most suitable for this study given the resources and time constraints for this study.

The sample for this study comprised 12 participants from the Ndebele culture, in the community of Middelburg, and its surrounding villages and townships, which were Mhluzi and KwaMalemane in Mpumalanga. The participants adhere to indigenous healing practices and ancestral belief systems such as consulting traditional healers and participation in rituals specific to Ndebele culture such as *ukuthomba* or *ingoma,* or other rituals shared by other black South African communities.

Demographic details of the participants

The participants were interviewed individually in the comfort of their surroundings in the town of Middelburg. The table below presents the demographic details of the participants. The sample of the study constituted of twelve (12) participants, six males and six females, between the ages of 24 and 65 years. The majority of the participants, in terms of their areas of residence, originated in either rural or suburban parts of Middelburg. In terms of

ethnicity, since the study focused on the Ndebele, the results showed that four of the participants are of royalty, and eight are not. Being of royalty is having the influence in the Ndebele community and the overall culture. What is meant by influence is the impact that the clan has in the culture, over generational stages, and with that influence, given the status and made of royal blood. Therefore, this dimension of influence and royalty status does inform participants' understanding of mental illness and treatment differently, because of the generational rearing, decision-making, status and indigenous knowledge phenomena. The ethnicity of the participants, which is ethnicity by birth, is significant because of the contribution they can make towards the study's research question. All these are presented in the table below:

TABLE 1: Demographic details of the participants

Name	**Age**	**Geographical area of Residence**	**Ethnicity**
Participant 1	65	Suburban	Royalty
Participant 2	50	Rural	Royalty
Participant 3	32	Suburban	Royalty
Participant 4	24	Suburban	Not of royalty
Participant 5	31	Suburban	Not of royalty
Participant 6	28	Rural	Not of royalty
Participant 7	29	Rural	Not of royalty
Participant 8	30	Suburban	Royalty
Participant 9	52	Rural	Not of royalty
Participant 10	62	Suburban	Not of royalty
Participant 11	51	Rural	Not of royalty
Participant 12	45	Suburban	Not of royalty

2.5. Instruments

This study used a semi-structured interview method. According to Gravetter and Forzano (2009), semi-structured interviews are utilised to extract in-depth information on a

participant's beliefs, perceptions or notions about a certain phenomenon for a study. The interview schedule was created based on the literature reviewed specifically that of Myers (2008), Makgabo (2012), Thompson (2007), Matjhiga (2006), Nkosi (2012), Huffman (2004) and Sehoana and Laher (2015), where in summary, the literature stipulates that semi-structured interviews bring about enquiry that combines a beneficial discussion for both the interviewer and the interviewee, with the opportunity for the interviewer to explore particular, specific, open-ended themes and responses.

The interview schedule consisted of 14 questions, which were divided into four components: 1) contextual questions relating to demographic information and background on the Ndebele culture, specifically the Southern Ndebele; 2) their understanding of mental illness; 3) the etiology of mental illness in the Southern Ndebele culture; and 4) the treatment of mental illness in the Southern Ndebele culture. The interview schedule was piloted with two lecturers at the University of the Witwatersrand who identify with the Ndebele culture.

2.6. Research Design

In this study, a qualitative research method was used. Green and Browne (2005) point out that qualitative research methods intend to reveal or explore meaning and expose facts that produce non-numerical data. The basic principles underpinning qualitative enquiry in the social sciences focus on a strong theory-based design, and the meaning of language needs to be considered in this approach and has specific implications for analysis of textual data based in interview narratives. According to Hancock, Windridge and Ockleford (2009), qualitative research is characterised by substantial inductive or open-ended questions based on the topic areas that the researcher wants to cover. It is an appropriate approach in social sciences for researchers interested in studying human behaviour (Boyce & Neale, 2006).

The type of qualitative method used in this study was phenomenology. According to Pietkiewicz and Smith (2012), phenomenology attends to the way things appear to individuals and is aimed at identifying the essential components of phenomena which make them unique and distinguishable from others, focusing on how people perceive and talk about objects and events (Pietkiewicz & Smith, 2014, p. 9). In addition,

phenomenology attempts to recognise the essential components that make a phenomenon special by interpreting the meaning of the subject at hand.

Transcendental phenomenology was used in this study. According to Creswell (2013), transcendental phenomenology focuses on the description of participants' experiences, identifying a phenomenon, bracketing out the experiences in a 'textual description' (what the participants experienced), and a 'structural description' (how the participants experienced the phenomenon at hand, its perceptions, looking at a situation and the context). The use of transcendental phenomenology focused on the Ndebele culture and how the culture may affect the perceptions towards mental illness. It identified the mental illness as the phenomenon, the participants' views of it, their experiences and how they view the phenomenon structurally and textually. Transcendental phenomenology aims at generating rich and detailed descriptions of an experience (Creswell, 2013), in this case, that of mental illness, hence the study of perceptions of mental illness amongst the Ndebele in the context of Mpumalanga.

2.7. Procedure

I created a list of the known Ndebele households in the area of Middelburg and its surrounding villages and townships, which are Mhluzi and KwaMalemane. This was done with my personal knowledge of the Ndebele households and the acquaintances I have in these areas. I selected the participants from those Ndebele households. The technique of snowballing was carried out by myself from the selected households and participants. The information sheet (Appendix A) was handed out as well, and participants who were interested in taking part were asked to be interviewed. The interviews were conducted by myself and were mostly conducted in English however language barriers were visible as participants felt more comfortable in expressing themselves in isiNdebele. As a Ndebele speaking person, I managed to accurately reflect on the participants' narrative meaning. The interviews were held in a neutral place, in the community hall of Mhluzi, called Eric Jiyane Hall, to ensure researcher/participant safety, as this hall is a community based public hall, with security services on the premises. The interviews were each approximately one hour long, beginning with an introduction of the study, briefly explaining its purpose, and allowing participants to read through the appendices. The

interviews were audio recorded, note taking was done, and the interviews were carefully transcribed for analysis.

2.8. Data Analysis

Once the data was collected and transcribed, interpretative phenomenological analysis (IPA) was used. IPA is an analytical technique that sets out to explore peoples' lived experiences in detail, examining how people make sense of their personal and social worlds, taking into account the contexts of cultural and socio-historical meanings as an interpretative process (Shinebourne, 2011). It is noted that there is no single way of doing IPA, but it involves intensive engagement in an interpretative manner with the transcripts (Smith & Osborn, 2007). The theoretical framework, the Biopsychosocial-Spiritual model, served to guide and inform the overall research process of data collection, and the interpretation of results, as an interpretive approach emphasizes the cyclical process of uncovering shared meaning between the interviewer and interviewee.

The stages which were used in analysing with IPA were to make notes using the interview transcripts, which were reread, and anything interesting or relevant was noted. These comments were then summarised. Once this was done, the themes emerged. I went back to the beginning of the notes and devised concise titles. Thereafter, the themes were connected and structured by listing the emergent themes and finding links between them. The initial connections were checked to see if there was coherent order of the theme titles, alongside any underlying subthemes. Finally, the themes were presented in a manner that provided a clear narrative, which continued in writing up the findings (Wilson & MacLean, 2011, p. 557–558).

2.9. Ethical Considerations

The ethical considerations which were taken into account were that written consent needed to be obtained. This was done with the consent forms in Appendix B. These, together with the Participant Information Sheet (PIS), were given to the participants to read through. A verbal explanation of these was given as well, in both English and IsiNdebele and consent was obtained from the participants before they participated in this study stipulating their agreement to participate. The participants received assurance of confidentiality. This means that no identifiable information about individuals, collected

during the research, was disclosed and the identities of participants were protected by the researcher. The participants were advised that their participation in the study was voluntary and that they could withdraw at any time should they wish to do so, without any repercussions.

The findings of the study will be made available to the participants on request. There were no risks or benefits for participants in this study. The audio tape recordings are to be stored for the duration of this study in a locked cupboard at the university after which they will be destroyed. Transcripts are to be kept on a password protected computer. As this study forms part of a larger study on mental illnesses across cultures, transcripts will not be destroyed until such time as the larger project is completed. Should the participants feel that they would like to talk to someone after the interview, or if they knew of someone who may need help, they could contact the free counselling services available of the PIS (Appendix A). Participants are free to contact the interviewer or her supervisor for any questions regarding the study. The contact details are made available on PIS (Appendix A) which will be given to participants, briefly informing them of the overall study and their participation in it. Feedback took the form of a one to two-page summary sheet that outlines the study and its findings.

2.10. Self-Reflexivity

Reflexivity is the practice of reflecting upon a research process, which forms the purpose of identifying subjective, contextual and bias factors that may influence the outcome of the study (Macbeth, 2001). It is of importance because, as a researcher, one needs to comprehend any issues that arose during the study, such as race, class and gender. The fact that I am a Psychology post-graduate, and I am also a Ndebele, may influence me as I interview, analyse and write up the results. Therefore, as the researcher, I was aware of my own beliefs and perceptions as a Ndebele woman, those being a strong believer of culture, however also religious in the same regard. In addition to my own beliefs, the interpretive approach further emphasized the uncovering of shared meaning between myself, the interviewer, and the interviewee, in a cyclical manner. In terms of ethics, bias was extensively monitored and regulated together with my supervisor and removed from my own personal understanding and being. In order to keep my bias in check, I kept notes

in a journal from the onset of the study, during the interviews, after the interviews, during data analysis and final report writing. This assisted in keeping records of any of my responses and/or reactions which could have potentially influenced the results. In addition, to establish credibility of the study, member checks were included. Member checks are when the transcripts and analysed texts are taken back to the participants to verify their accuracy and the interpretations of what they said, at the same time reinforcing collaborative and ethical relationships between the researcher and the participants (Babbie & Mouton, 2001; Yin, 2011).

2.11. Conclusion

This chapter explored the methods applied for collecting and analysing the data for the study. In the next chapter, the results obtained from the interpretative phenomenological analysis will be presented and reported.

CHAPTER 3: RESULTS

Primarily, this chapter presents the results of the research which was conducted in Middelburg, Mpumalanga Province, with a total of twelve (12) participants. The chapter outlines and discusses the explication, the interpretation of analysis which comprises of the foregrounded themes and subthemes which emerged from the participants' responses and the literature. These were notions of mental illness, the causes and treatment of mental illness, stigma, cultural importance, and the Ndebele as a culture versus the 21st century.

3.1. Notions of mental illness: Abnormal behaviour

This study stimulated the notions of distress, feelings and behaviours, and further addressed how the community reflects on and perceives mental illness as a phenomenon. Participant 3 stated:

> *"Mentally ill people are crazy! They do weird things like talking to themselves, picking up papers on the street, and any other behaviour that isn't done by normal people…".*

Participant 9 further reported,

> *"I did not have any formal education growing up, but what I can say is that I understand mental illness as a problem with the brain. You cannot see this illness physically, such as weight loss, but the person's behaviour changes".*

Emphasis on the seriousness and the existence of mental illness was expressed by participant 9, who stated that,

> *"mental illness is an illness of the mind, such as depression, where the person is 'not okay upstairs'…"*

Participant 10 added:

> *"This illness actually exists! Initially I did not believe in such an illness, but now I know and confidently say that it exists. It is mainly based on abnormal and crazy behaviours".*

A variety of definitions have been noted, but all have common factors, of abnormal

behaviour, abnormality of the brain and of the mind.

3.2. Causes of mental illness

Mental disorders are often perceived as a source of misfortune and ancestors and witches are believed to have a crucial role in causing them (Kabir, Abubakar & Aliyu, 2004). Themes that emerged based on the above mentioned reasons are those of witchcraft and punishment.

3.2.1. Witchcraft

The findings of this study, with n = 7, including the causes of mental illness, have shown negative cultural aspects. Participant 2 reported that

> *"There are a lot of causes, but it is based mainly on witchcraft and ancestors. People get bewitched because of their intelligence in our area, and the people that bewitch them do not want them to succeed in life, making them go crazy and become unaware of the world in general".*

Participant 3 also said that

> *"I do not know the exact causes of mental illness, but what I know is that is it caused by two situations; either witchcraft or health …".*

Additionally, participant 7 agreed with the notion of witchcraft and said that

> *"The cause is simply witchcraft! No matter what professionals say, as a traditional man, I believe it is because of the evil spirits that possess a person, due to different reasons".*

Some participants did acknowledge that studies say that mental illness is mainly a western approach, focusing on the fundamentals of the environment and clinical analysis (Skhosana, 2010). Participants 10 and 6 reported the following respectively:

> *"There are many demonic realms that play a role in this, however, because of the knowledge we are exposed to now, I can say mental illness can be caused by genes".*

> *"Mental illness is caused by things such as trauma, meningitis and a large area of a lot of past experiences".*

3.2.2. Punishment

The following themes trace back to perspectives of traditional practices, according to Nkosi (2012), where "causes of mental illness and disease may be traced in social, cultural or spiritual realms, and this sometimes sounds untrue – but the truth of the matter is that these realms cause disease, including spiritual intrusion and ignorance" (p. 88). Participant 4 expressed this perspective as,

> *"Mental illness is also a form of punishment from the ancestors, where one has been called, for instance, to be a traditional healer. If you ignore this calling, these spirits may cause you to lose your mind".*

Participant 1 further elaborated on this notion of punishment, and which is specific to the Ndebele culture:

> *"Ignoring cultural traditions, like the boys' rite of passage ceremony, going to the mountain for circumcision, can definitely lead to mental illness, as this has to be done in the Ndebele culture".*

This subtheme of punishment emphasises that culture, more specifically the Ndebele culture, does have some form of influence on mental illness and its causal effects being the result of cultural practices. This phenomenon led to the treatment phase of mental illness, a theme that emerged throughout the study. The methods considered acceptable for curing illness have been seen to vary significantly. Treatment of mental illness has been thought of as both traditional healing and health services.

3.2.3. Treatment of mental illness: Perceptions of Indigenous Traditional forms of healing

As it was stated in the literature, traditional medicine is believed to be used in various ways. Studies have displayed that there is a great emphasis on traditional healers who are the primary health care providers for mental health and are pursuited by the global community, states Ngobe (2015). Participant 11 said:

> *"Upon diagnosing a mental illness, a traditional healer can give the patient herbs, in forms of a plant or a liquid; however it may not cure the illness but can maintain it throughout the persons' life".*

Participant 6 elaborates on the notion of traditional healing as stated by participant 11 above:

> *"A traditional healer is a very powerful healer who can first determine the illness by throwing bones and seeking guidance from the ancestors. With this done, the healer can know exactly what to give the patient in order for him or her to heal".*

Some participants mentioned that both ways of treatment, medicine from hospitals and traditional healing, can work simultaneously. Participant 12 reported:

> *"Treatment of mental illness depends on exactly the mental illness. In some cases, they would need counselling or clinical assistance and, in other cases, brainwashing from a traditional healer is needed".*

Participants also mentioned that both ways of treatment can work simultaneously, in this instance, using traditional medicine:

> *"Maintaining the mental illness needs the medication and counselling to come together with traditional healing".*

3.3. Stigma attached to mental illness

One of the most influential themes that emerged is that of stigma, as it has a negative impact on gaining knowledge and seeking treatment. Corrigan, Thompson, Lambert, Sangster, Noel and Campbell (2003) state that stigma has been identified as a key barrier, not only to treatment, but also to the manageable way of life opportunities for persons with mental illness. Participant 7 elaborated on the issue of stigma:

> "I know of a community member who got sick, and was mentally ill. The children made fun of him, and elders of the community turned their backs on the family".

Participant 10 agreed with participant 7, on stigma, and suggested a solution:

> *"If only the society would get involved in assisting the mentally ill, the stigma regarding mental illness would come to an end".*

3.3.1. Affordability of services

A subtheme of stigma is the economic status of the affected. The affordability of mental

health care services, the treatment and medication was highlighted by the participants (n = 6). Participant 7, agreeing with the theme of stigma stated that,

> *"To make matters worse, the family's financial state was bad where they could not afford to take their son to a medical or traditional professional".*

Participant 10 further emphasised the financial strains of patients and those affected,

> *"not only would the stigma end, but also assist financially".*

3.4. Cultural importance in the Ndebele community

The findings of this study suggest that a common culture keeps a community unified. Participants (n = 8) mentioned the importance of culture in the community, and the aspects of unity. How one thinks and acts determines the cultural views of mental illness. According to Participant 7, their perception on culture is based on

> *"When one is raised in a traditional home, there is harmony. Things go well, not only for me but for the whole family and future generations to come".*

Participant 4 reported,

> *"I was raised by my grandparents, whom enforced culture on us, even though my mother was Pedi, the Ndebele customs are what I say groomed me today, and also how the Pedi and Ndebele cultures interacted in my life, played a powerful role in my life, and are still are".*

Participant 3 further reported,

> *"I love how unified and together the community is. Mhluzi is a small place, but the togetherness we all show, especially when it's time for ingoma. (male initiation ceremony), that is when you see that culture is important and needs to be done forever".*

This theme shows that unity in a community leads to an understanding of individuals in the community and a solid foundation.

3.4.1. Ndebele as a culture versus the 21st century

Even though culture is important, some participants noted that their upbringing in the 21st

century did not include learning about their culture.

Participant 8 stated:

> *"Honestly, I personally do not necessarily follow culture, because I grew up in the modern times, and I am still young and do not see the need now. Technology and the western culture is what I live by now and I am okay with it…"*

Participant 4 added:

> *"I am an Ndebele, yes, but I do not have any knowledge on the culture. I was basically spoiled and I didn't face any challenges. My childhood was beautiful and westernised; hence I do not have any connection with the Ndebele culture".*

Growing up in modern times has also has a negative aspect. Participant 12 noted:

> *"I can say I have had a good upbringing, and a good education. However, this came with heartache. My mother was never around, as she had 2 jobs and jobs which were far away from us. I went to a multi-racial school, where I was the only black child in class, which resulted in me experiencing a lot of stereotypes and I never had friends to play with, as I was labelled a 'coconut' (sigh). If only my mother was around, and we didn't grow up in the suburbs, and was actually taught about tradition, I would have reacted better to life in general".*

Participant 11 felt strongly about the lack of traditional culture today:

> *"Culture and tradition are fading and dying. Look now, it is scarce to find teenagers that can speak isiNdebele, because of the model C schools that they are in. I am not saying it's a bad thing that they are learning in English, but nowadays all they do is speak English even emakhaya (at home)".*

Participant 1's response highlighted the subtheme:

> *"… As a grandfather of six, I have seen a lot of disrespect from the children, because of the lack of tradition and being told that this is the 21st century now. If only they had grown up in our times, where culture was valued above everything, we wouldn't have high levels of crime, teenage pregnancies and addiction, for instance, now".*

This subtheme shows how culture can influence one's life, especially by looking at how

participant 12 mentions traditional teachings.

3.4.2. Competence and Performance

Two themes that emerged from the study were, firstly, competence that Chomsky (2006) defines as an "idealised capacity that is located as a psychological or mental property" and, secondly, "performance which is defined as the production of actual utterances" (Chomsky, 2006: 95). In this study, participants mentioned that culture, tradition and beliefs in relation to the mentally ill should not only be what they think (competence), but should also be what they actually do to represent those thoughts (performance). Participant 12 stated this view, by starting off with a question, which is an indirect manner of choosing not to pick a stance:

> *"Do you really want to know what I think? In order for me to fully answer a question about mental disabilities, I need to know what actually happens and have an experience of it. My thoughts are important, yes, but, as an Ndebele, I have to know the basic things of the culture, then only will I know how and why a mentally sick person would be treated in this way".*

Participant 7 mentioned the effects of treatment and how negative behaviours come from competence:

> *"... if I treat people badly, that alone should represent what I think in the beginning..."*

Participant 5 observes causal effects in a competent manner, which means that one ought to see and know initially before 'performing':

> *"The Ndebele people and many other cultures believe that when uloyiwe (bewitched), is when the mental sickness starts. But in order to say that, you must first understand, see and know someone who is bewitched".*

This statement exhibits an in-depth knowledge of what the individual versus the culture portrays as thought and/or action.

3.4.3. Language: "The known and the unknown"

Language is a common phenomenon and way of life. Participant 12 began by mentioning aspects of language and terminology:

"Mental illness is a very dangerous and life-threatening disorder, and as a qualified psychologist, I feel that only us professionals understand what it really entails, what is needed for curing it and overall journey it possesses …"

Participant 12 also gave examples of the language barriers, by clarifying what the known would be versus the unknown:

"…for instance, if the family, or the mentally ill person does not understand what they have, then it is an impossible mission to intervene in because in most instances, they are not English speakers and the DSM, together with the speakers, are of an English based foundation. So if we don't bridge the gap of language barriers then we are going to continue going around in circles, trying to intervene and assist within the mentally ill".

Participant 7 expressed his/her personal views of constructions in a language that is not their mother-tongue:

"You see, even now I am battling to answer imibuzo yakho (your questions) because I am not strong in English … doctors can say I have a disease that I do not understand. Not that I am stupid but because I do not understand what he is saying".

Participant 4 validated language as the known, in the case of mental illness knowledge, by stating that

"I am grateful that I got the chance to study, and I know that mental illness is a psychological disorder that can affect anyone. But what about those people that do not know English? Are there ways to explain it to them in their mother-tongues?"

3.5. Conclusion

This chapter presented the results of the research which was conducted in Middelburg, Mpumalanga Province, with a total of 12 participants. Firstly, the chapter outlined and discussed the content which comprised the themes and subthemes which emerged from the participants' responses and the literature; notions of mental illness, the causes and treatment of mental illness; stigma; cultural importance, competence and performance, the Ndebele as a culture versus the 21st century and language. Lastly, conclusions will be drawn on the latter issues in the next chapter, thereby providing summaries of the

findings.

CHAPTER 4: DISCUSSION

This chapter focuses on discussing the themes that emerged in the previous chapter, relating to overall studies of mental illness. The content of this discussion is that which mimics the results, which are, the notions of abnormal behaviour, the causes and treatment, looking at witchcraft, punishment and traditional healing, the notions of stigma, and lastly, the cultural importance in the Ndebele community.

4.1. Notions of mental illness: Abnormal behaviour

Butcher, Mineka and Hooley (2010) state that mental illness is seen as a clinical, consequential psychological or a behaviour problem that is connected with distress and disability. It is also classified as diagnosable disorders, which inhibit thoughts, feelings and behaviours, elaborates Ngobe (2015). Mental illness, according to Ngobe (2015) is a highly prevalent, life-threatening disease that affects people globally. It does not discriminate and it affects people of all ethnic groups and economic levels. Looking at the term on its own, 'mental illness', one can say that a mental component has to do with the mind or brain. The results manifest a stance of behaviour, and an emphasis on the term "crazy". Most of the participants' results stipulated a lack of in-depth knowledge on mental illness, as they did attest to not knowing exactly what mental illness is, not having formal education, and disbelief. According to the socio-economic status domains of this country, the disadvantages of education still continue to pose challenges, and correlations are seen which link the poor to lack of education, meaning lack of knowledge, therefore this contributing to the minor information known about mental illness (Mkhize & Kometsi, 2008). Therefore, to adequately understand the aspect of mental illness, we need to understand the origin and the nature that shape the cultural values and perceptions of people, especially in regards to notions of what mental illness is, its cause and effect (Skhosana, 2010; Ngobe, 2015). However, some participants did specify that mental illness is an illness such as depression. This shows clear and concise understanding of the broad aspects of defining mental illness, which is supported by the World Health Organization (WHO, 2008), by stating that mental illness hinders a person's everyday

ability.

With this said, a portion of mental illness, as a disease of the mind, participants stated that it is not a physical illness, but a psychological one, where abnormality is seen in the person's behaviour, speech and emotion. Therefore, I can say that there is awareness of mental illness, and how it is perceived, varies from person to person, and from community to community.

4.2. Causes and treatment of mental illness

Several studies have stated the causes of mental illness, and for many Africans, the cause of disease relates to conflict or tension between good and evil, and harmony and disharmony (Ngobe, 2015). With reference to the causes and treatment of mental illness, the participants expressed a connection between ancestry, witchcraft, and a westernised component to it.

4.2.1. Witchcraft

The results of the causal factor of witchcraft, stipulate that people are the actual cause of mental disturbances. People, as a cause, are in a sense of them bewitching others, resulting in mental illness. Another factor is that of possession, evil spirits and demonic realms (p.7 & p.8), and Ukpong and Abasiubong (2010) attest to this by covering a section on "possession and ukuthwala" in their study. Furthermore, Ndlovu-Gatsheni (2005) states that the results of mental illness are due to ancestors being angry and unhappy, which leads to illness and ultimately death. Therefore, mental illness includes the beliefs that a person is either possessed by demons, is the victim of witchcraft, or is suffering because some rituals were not performed accordingly, or not performed at all (Engelbrecht & Kasiram, 2012).

However, awareness is also mentioned by participants that components such as genetics, trauma, disease and past experiences, do result or contribute to mental disturbance.

4.2.2. Punishment

Continuing from witchcraft, causes of mental illness may be a result of punishment from the ignorance of traditional practices.

Participants state that this form of punishment comes from ignoring a calling to be a traditional healer, and also the rite of passage rituals, more specifically within the Ndebele culture. Mashiyane (2002) adds on by elaborating that, things like religion, child rearing practices, values and ideals, are important factors of conformity, and with this not being followed, contributes significantly towards a person's development. Therefore, culture influences the perceptions of mental illness, in a sense that it is because of the latter mentioned structures and activities, which cause mental illness.

4.2.3. Perceptions of Indigenous traditional forms of healing

In regards to treatment, the results pointed out some emphasis on both traditional treatment and western medication. The eminent treatment for mental illness is provided by a multidisciplinary team, comprising of medical practitioners, psychologists, nurses, psychiatrists, priests and / or traditional healers, to address the varied yet interchangeable needs of the ill individual (Neille, 2013; Ngobe, 2015; Butcher et al., 2010). Most of the participants stated that mental illness cannot be cured, but can be maintained, using the above mentioned healers, in order to guarantee a definite maintenance of the mental disorders.

The results also approached a method of 'brainwashing, where psychologists or traditional healers tackle a "cleansing", where the individual can receive sufficient treatment. It may be by means of medicine, herbs, group counselling, and rehabilitation programmes (Ngobe, 2015). Brainwashing, in regards to the subtheme, relates to the treatment phase, where influence, conditioning and perhaps persuasion, is an approach to be utilized in the treatment of mental illness (Agassi, 1990). Therefore, the results emphasized the need for multidisciplinary teamwork, in order to treat mental illness, in a holistic manner.

4.3. Stigma

Of interest to this study, is how stigma influenced the individual, the families, and overall community's stance on seeking and getting help. The results are to also see how it made an impact in the developments, dealing with, and treating mental illness. According to Kabir et al., (2004), community attitude and beliefs play a role in determining help-seeking behaviour and successful treatment of the mentally ill, and ignorance and stigma actually

prevents the mentally ill, and those affecting, to seek appropriate help.

With this said, a participant stated how the community made fun of a mentally ill person, and did not assist in any way, this attesting to the above mentioned recognition of how the community impacts treatment. "Families of people with mental illness believe negative stereotypes contribute to the stigma associated with mental illness, resulting in social rejection of those with mental illness" (Thornton & Wahl, 1996), agreeing with the results that if only the community would associate themselves with the ill, the stigma would eventually come to pass.

4.4. Cultural importance in the community

Culture is of a sentimental value, a way of life, and can be seen as a collection of historical cultures borrowed from other African cultures (Mashiyane, 2002).

4.4.1. Ndebele versus the 21st century

The Ndebele culture has been renowned for its diverse colourful textiles and appearance, family, traditional beliefs, dance, music, beadwork, and the levels of hierarchy to name a few, and when one looks at prior historical doings, versus this day and age, there has been a change (Mabena, 1999; Matjhiga, 2006).

The results postulated how important it is growing up in a culturally grounded setting, and also showed the disadvantage of not growing up in such a setting. Looking at the results, especially when one dwells upon the demographics of the participants, one can see the age-gap relations, because the older participants are the ones that are for culture, value, tradition, and are knowledgeable in regards to culture, and the younger participants see the negatives such as stereotypes, and do not truly follow culture.

This may be a result of upbringing, background, lack of information, and the changing times, where Mabhena (1999) attests by saying that the already available literature on the culture of Ndebele consists of a small body of knowledge, and this is because of only a small group of people who have had an interest but have not received any formal training regarding this part of culture.

4.4.2. Competence and Performance

The domain of competence and performance summarises as competence is being involved in knowing the particular aspect, and performance involves doing something with that aspect (Chomsky, 2006). With the results seen, the participants emphasised the variances that being competent in understanding the Ndebele language, or English, or mental illness, depends entirely on how one's actions and performance represent that understanding. This is supported by Chomsky (2006) who states that it is difficult to assess competence without performance. Therefore, one needs to understand the 'knowing' and the 'doing' what the Ndebele culture entails, what mental illness entails, its causals and treatment, before one can actually dwell on it and be confident in its understandings and manifestations.

4.4.3. Language – "the known versus the unknown"

Language is defined as the expression or communication of thoughts and feelings by means of sounds, and combinations of such sounds, to which meaning is attributed, as human speech (Ashcraft and Radvansky, 2010: 210). In a more socio-based generalised manner, language, to most of us, using our native language comes as naturally as breathing, yet using language actually involves a host of complex skills (Passer and Smith, 2011). In the case of this study, the complexity of language is emphasised on the dominant use of English as a medium language, in schools, education, academia, research and health. An emphasis is made on the level of not knowing English, in regards to understanding diagnoses and treatment of mental illness. The subtheme also makes emphasis of what is known to the participants, and also the unknown, in how these may contribute to the influence towards mental illness. However, further focus is made upon the expectations of a native language, isiNdebele, in that it is fading away and may eventually die out as a result of not being utilised in spheres such as that of the homestead.

4.5. Conclusion

This chapter focused on discussing the themes that emerged in chapter 3, relating to overall studies and the literature of mental illness. The content of this discussion was that which boiled down from the results, which were the notions of abnormal behaviour, the

causes and treatment, looking at witchcraft, punishment and traditional healing, the notions of stigma, and lastly, the cultural importance in the Ndebele community.

In regards to the notions of abnormal behaviour, the perceptions of mental illness stated that mental illness is seen differently across different borders of cultures, and societies. An example to this is the practicality of the guidance of how the theoretical framework of this study has uncovered shared meaning and perhaps understanding, between myself and the participant. The society of Mpumalanga, and the culture of the Ndebele, stipulated their position as a society, in the various aspects of behaviours, functioning and socioeconomic domains. The behaviours are elaborated further in the causes of mental illness, where the etiology of mental illness was based on the western perspectives and the non-western perspectives, which stated that mental illness often occurs due to other diseases, stressors, or trauma, versus mental illness caused by what is stated as darkness and light (Nkosi, 2012), which may be possession, witchcraft and other spiritual omens.

Treatment of mental illness varies excessively, due to the different livelihoods people possess and live in. In African beliefs, consulting a traditional healer is common than a western form of treatment such as therapy, and the results stipulated that, a joint treatment approach would be beneficial, where African treatments and the Western treatments are intertwined, to reach the ultimate cure. Stigma was a dominant factor in the study of mental illness, more specifically in the cultural aspects. Mentally ill individuals, and their families, become the focus of negative treatment, and they experience maltreatment, prejudice behaviour, and mostly stigmatization (Engelbrecht & Kasiram, 2012). This brings into further insight of understanding what the important aspects of the Ndebele culture are, how these have an impact towards the mental illness domain, and the influence it possesses. The results prove that culture is very important, in regards to the past knowledge and ways of living, the language, and what is known. These tremendously played a role in identifying the cultural levels of understanding mental illness, levels being the participants' ethnicity; royalty or not royalty; the age; the area of focus; and the socioeconomic status.

With this said, the study experienced challenges and hurdles, which are the limitations of

the study, and recommendations of the study are made for future research.

CHAPTER 5: LIMITATIONS AND RECOMMENDATIONS

This chapter explores the limitations of the study and makes recommendations for future research. The limitations of the study were: the lack of literature on the Ndebele culture and on the Ndebele cultural perceptions of mental illness; the lack of interviews, interest and participation in the study; and the possible influence of the researcher's knowledge on the concept of mental illness and Psychology.

5.1. Limitations of the study

5.1.1. Limitations regarding the Ndebele culture literature and literature on their perceptions of mental illness

This study explored the Ndebele culture and its perceptions of mental illness among the community of Middelburg, in the Mpumalanga Province. There is limited literature on the culture of the Ndebele overall, let alone about mental illness. Mabena (1999) attests to this by stating that the available literature on the culture of the Ndebele consists of a limited amount of knowledge, therefore the culture cannot be clearly traced back to its origin. This created a challenge in terms of comparing differences and similarities of the study with more recent researched work however, other available South African and African studies assisted in comparing cultural aspects of mental illness.

5.1.2. Limitations on interviews, interest and participation

This study aimed to involve 10 to 20 participants ranging from 24 to 65 years of age of royalty or non-royalty, in a balanced and linear manner. However, it was difficult to locate the sample because of a lack of availability, time-constraints and a lack of interest, resulting in 12 participants, which still met the requirements. In retrospect, participants' level of education, type of religion, economic circumstances and living arrangements were not included, and these contextual dimensions would have informed the way in which the participants hold and reflect their understanding of mental illness.

5.1.3. Limitations regarding researcher's detailed knowledge on the topic of mental illness

As stipulated in the information sheet, the fact that I am a Psychology post-graduate

student and I am also Ndebele, may have inhibited understanding of the results, and may have influenced the outcome of the study. Because I have been immersed in this topic, my detailed knowledge of the topic of mental illness may have impacted the participants' general understanding of the topic. However, in terms of ethics, bias was extensively removed from my own personal understanding.

5.2. Recommendation for future research

The recommendations begin with the continuation of further studies on the Ndebele culture, and its notions of mental illness, in rural and semi-urban places. This is because Neille (2013) states that South Africa still faces challenges relating to limited resources, a shortage of knowledgeable professionals and the burden of communicable and non-communicable diseases. Such professionals are needed to further research and publish articles that explain the Ndebele community's understanding of illness.

Furthermore, community awareness can be raised by handing out pamphlets or holding workshops on the phenomenon of mental illness to enhance the community members' knowledge and interest in mental illness.

Contextual relevance, such as the participants' level of education, play an important role on the perceptions, stigma, causes and treatment of mental illness, therefore these require further visibility and acknowledgment, in being included in the demographics of the participants.

This study focused on the Ndebele culture hence other researchers can further the aims of the study by involving the Nguni cultures (Zulu, Swazi, Xhosa and Ndebele), because Skhosana (2009) states that, in close observation of the traditions of amaNdebele, it is noted that they demonstrate distinct Nguni ethnic characteristics. This may assist in understanding, growing the literature, and studying the Ndebele culture.

5.3. Conclusion

This study focused on the Ndebele culture and its perceptions of mental illness. This chapter explored the limitations of the study which included the literature of the Ndebele culture and its perceptions of mental illness. This was followed by the limitations of the interviews, interest and participation in the study with regards to sampling and the

possible influence of the researcher's knowledge of mental illness. This chapter concludes with recommendations for further research.

This study explored the Ndebele culture and its perceptions of mental illness. Community members play an important role in the individuals' well-being in the community, particularly those who are mentally ill and those who are impacted by this illness.

This study firstly conducted a literature review about the concept of mental illness, as the focus of the whole study, in Chapter 1. The literature review covered the Ndebele people, their history, background, culture and language. The literature review also explained the important aspects of the Ndebele culture, the perceptions of mental illness, the cultural aspects of mental illness and the etiology. It concluded with the various approaches to the treatment of mental illness.

Chapter 2 explored the methods used for this study by outlining the aim, rationale of the study, research questions, sample, instruments, research design, data analysis and ethical considerations.

Chapter 3 presented the results of the study, firstly, by tabulating the demographics of the participants. This was followed by the themes that emerged, which are: cultural importance in the Ndebele community, notions of mental illness and abnormal behaviour, causes and treatment and, lastly, stigma.

Chapter 4 discussed the results of the study as they related to the aforementioned themes.

Chapter 5 explored the limitations of the study, made recommendations for future research and concluded the study. These recommendations will be able to assist the community of Middelburg and other small communities as well.

REFERENCES

Agassi, J. (1990). Brainwashing. *Methodology and Science, 23*, 117 – 129.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington DC: American Psychiatric Association.

Angermeyer, M. C., & Matschinger, H. (2003). The stigma of mental illness: Effects of labelling on public attitudes towards people with mental disorder. *ACTA Psychiatrica Scandinavica, 108*, 304–309.

Ashcraft, M. H., & Radvansky, G. A. (2010). *Cognition* (5th ed.). Boston, MA: Pearson.

Babbie, E., & Mouton, J. (2001). *The practice of social research.* Cape Town, South Africa: Oxford University Press.

Beng, K. S. (2004). The last hours and days of life: A biopsychosocial-spiritual model of care. *Asia Pacific Family Medicine, 4,* 1–3.

Boundless. (2016). *The biopsychosocial model of health and illness.* Retrieved from http://www.boundless.com/psychology/textbooks/boundless-psychology-textbook/stress-and-health-psychology-17/introduction-to-health-psychology-85/the-biopsychosocial-model-of-health-and-illness-326-12861/

Boyce, C., & Neale, P. (2006). *Conducting in-depth interviews: A guide for designing and conducting in-depth interviews for evaluation input.* Watertown, MA: Pathfinder International.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*, 77–101.

Burke, A. (Ed.). (2012). *Abnormal psychology: A South African perspective.* Cape Town, SA: Oxford University Press.

Butcher, J. N., Mineka, S. M., & Hooley, J. M. (2014). *Abnormal Psychology* (15th ed.). New York, NY: Pearson Education Limited.

Byrne, P. (2000). Stigma of mental illness and ways of diminishing it. *Advances in Psychiatric Treatment, 6,* 65–72.

Chavunduka, G. L. (1994). *Traditional medicine in modern Zimbabwe.* Harare: University of Zimbabwe.

Chomsky, N. (2006). *Language and mind* (3rd ed.). Cambridge: Cambridge University Press.

Corrigan, P., Thompson, V., Lambert, D., Sangster, Y., Noel, J. G., & Campbell, J. (2003). Perceptions of discrimination among persons with serious mental illness. *Psychiatric Services, 54*(8), 1105–1110.

Creswell, J. W. (1998). *Qualitative inquiry and research design: Choosing among five traditions.* Thousand Oaks, CA: SAGE Publications.

Creswell, J. W. (2013). Approaches to qualitative enquiry. In J. W. Creswell, *Qualitative inquiry and research design*. Thousand Oaks, CA: SAGE Publications.

Delius, P., & Hay, M. (2009). *Mpumalanga: An illustrated history.* Johannesburg, South Africa: The Highveld Press.

Dinosa, S., Stevens, S., Serfaty, M., Weich, S., & King, M. (2004). Stigma: The feelings and experiences of 46 people with mental illness. *British Journal of Psychiatry, 184*, 176–181.

Edwards, S. D. (1986). Traditional and modern medicine in South Africa: A research study. *Social Science & Medicine, 22*(11), 1273–1276.

Egbe, C. O., Brooke-Sumner, C., Kathree, T., Selohilwe, O., Thornicroft, G., & Peterson, I. (2014). Psychiatric stigma and discrimination in South Africa: Perspectives from key stakeholders. *BioMed Central Psychiatry, 14*(191), 1–14.

Egger, J. W. (2013). Biopsychosocial medicine and health: The body mind unity theory and its dynamic definition of health. *Psychologische Medizin, 1*, 24–29.

Engelbrecht, C., & Kasiram, M. I. (2012). The role of Ubuntu in families living with mental illness in the community. *South African Journal of Family Practice, 54*(5), 441 – 446.

Fallot, R. D. (2001). Spirituality and religion in psychiatric rehabilitation and recovery from mental illness. *International Review of Psychiatry, 13,* 110–116. Doi: 10.1080/09540260120037344.

Friesen, N., Henriksson, C., & Saevi, T. (Eds.). (2012). *Hermeneutic phenomenology in education*. Rotterdam, Netherlands: Sense Publishers.

Gravetter, F. J., & Forzano, L. B. (2009). *Research methods for the behavioural sciences*. Belmont, CA: Wadsworth Cengage Learning.

Gray, A., & Vawda, Y. (2016). Health Policy and Legislation. In A. Paradeth, J. King, E. Mackie, & J. Casciola (Eds.), *South African Health Review, Durban: Health Systems Trust*. Retrieved from http://www.hst.org.za/publications/south-african-health-review-2016

Green, J., & Browne, J. (2005). *Principles of Social Research*. London, UK: McGraw Hill.

Hadebe, S. (n.d.). *The significance of Ndebele historical fiction* [Brochure]. Zimbabwe: African Languages & Literature.

Hancock, B., Windridge, K., & Ockleford, E. (2009). *An Introduction to Qualitative Research*. Retrieved from http://www.rds-yh.nihr.ac.uk/wp-content/uploads/2013/05/5_Introduction-to-qualitative-research-2009.pdf

Hatala, A. R. (2013). Towards a biopsychosocial-spiritual approach in Health Psychology: Exploring theoretical orientations and future directions. *Journal of Spirituality in Mental Health, 15*(4), 256–276. Doi: 10.1080/19349637.2013.776448

Hofmeyr, I. (1993). *"We spend our years as a tale that is told": Oral historical narrative in a South African Chiefdom*. Johannesburg: Witwatersrand University Press. (Article was produced for the South African History online on 24 March 2011).

Huffman, T. N. (2004). The archaeology of the Nguni past. *Southern African Humanities, 16,* 79–111.

Jorm, A. J. (2000). Mental health literacy: Public knowledge and beliefs about mental disorders. *The British Journal of Psychiatry, 177,* 396–401. Doi: 10.1192/bjp.177.5.396

Kabir, M., Iliyasu, Z., Abubakar, I. S., & Aliyu, M. H. (2004). Perception and beliefs about mental illness among adults in Karfi village, northern Nigeria. *BMC International Health and Human Rights, 4*(3), 1–5. Doi: 10.1186/1472-698X-4-3

Kakuma, R., Kleintjies, S., Lund, C., Drew, N., Green, A., Flisher, A. J., & The Mental Health and Poverty Project Research Programme Consortium. (2010). Mental health stigma: What is being done to raise awareness and reduce stigma in South Africa? *African Journal of Psychiatry, 13,* 116–124.

Khumalo, L. (2005, July). *Considerations for providing etymological information in the advanced Ndebele dictionary.* Paper presented at the 10th International Conference of the African Association for Lexicography, University of Free State, Bloemfontein, S. A.

Kirmayer, L. J. (2012). Cultural competence and evidence-based practice in mental health: Epistemic communities and the politics of pluralism. *Social Science & Medicine, 75,* 249–256. Doi: 10.1016/j.socscimed.2012.03.018

Lakhan, S. E. (2006). *The biopsychosocial model of health and illness.* Retrieved from http://creativecommons.org/licences/by/2.0/

Latzer, Y. (2003). Traditional versus western perceptions of mental illness: Women of Moroccan origin treated in an Israeli mental health center. *Journal of Social Work Practice, 17*(1), 77–94.

Link, B. G., Yang, L. H., Phelan, J. C., & Collins, P. Y. (2004). Measuring mental illness stigma. *Schizophrenia Bulletin, 30*(3), 511–541.

Mabena, D. K. (1999). *The role of initiation schools in the identity formation of Southern*

Ndebele adolescent boys (Master's dissertation). University of South Africa, Pretoria.

Macbeth, D. (2001). On "reflexivity" in qualitative research: Two readings, and a third. *Qualitative Inquiry, 7*(1), 35–68.

Madzhie, M., Mashamba, T. M., & Takalani, F. J. (2014). African traditional healers' perception and diagnosis of mental illness. *African Journal of Physical, Health Education, Recreation and Dance, 1*(2), 319–328.

Magid, A. A. (2011). African indigenous knowledge systems: Challenges and opportunities. *Africa Insight, 40*(4), 136–148.

Makgabo, C. J. (2012). *A phenomenological study of the perceptions on childhood mental illness by Northern Sotho-speaking elderly people in Mankweng community, Limpopo Province* (Master's dissertation). University of Limpopo, Polokwane. Available from the University of Limpopo dissertations and thesis database.

Mashiyane, Z. J. (2002). *Some sociolinguistic aspects of Southern Ndebele as spoken in South Africa* (Master's Dissertation). University of Zululand, Richards Bay, KwaZulu-Natal.

Matjhiga, J. T. (Ed.). (2006). *A cultural image of South Africa: The IsiNdebele-speaking people*. Alberton, SA: Lectio Publishers.

Mazarire, G. C. (2003, November). *Who are the Ndebele and the Kalanga in Zimbabwe?* Paper prepared for the Konrad Adenuer Foundation Project on 'Ethnicity in Zimbabwe', Zimbabwe.

Mehraby, N. (2009). Possessed or crazy? Mental illness across cultures. *Psychotherapy in Australia, 15*(2), 43–50.

Mkabela, Q. N., & Castiana, J. P. (2011). Indigenous knowledge systems: The challenge. *Indilinga – African Journal of Indigenous Knowledge Systems, 10*(1), 5–9.

Mkhize, N., & Kometsi, M. J. (2008). Community access to mental health services:

Lessons and recommendations. *PsycINFO, 9*, 103–113. Doi: http://www.apa.org/psycinfo

Moyo, H. (2013). Religion and African indigenous knowledge systems: Healing and communal reconstruction in African communities. *Alternation, 11*, 207–236.

Mowbray, C. T., & Holter, M. C. (2002). Mental health and mental illness: Out of the closet? *Social Service Review, 76*(1), 135–179.

Mufamadi, J., & Sodi, T. (2010). Notions of mental illness by Vhavenda traditional healers in Limpopo Province, South Africa. *Indilinga – African Journal of Indigenous Knowledge Systems, 9*(2), 253–264.

Myers, D. G. (2008). *Social psychology* (9th ed.). New York, NY: McGraw-Hill.

Ndlovu-Gatsheni, S. (2005). Quarrying African indigenous political thought on governance: A case study of the Ndebele state in the 19th century. *Indilinga – African Journal of Indigenous Knowledge Systems, 4*(2), 449–470.

Ndlovu-Gatsheni, S. J. (n.d.). *The Ndebele nation: Hegemony, memory, historiography* [Brochure]. Europe: Rozenberg Publishers. ISBN 978 90 3610 136 3.

Neille, J. F. (2013). *Context, culture and disability: A narrative inquiry into the lived experiences of adults with disabilities living in a rural area* (Doctoral thesis). University of the Witwatersrand, Johannesburg.

Ngobe, A. J. (2015). *Swati traditional healers' conceptualization of causes and treatment of mental illness* (Master's dissertation). University of Limpopo, Polokwane, Limpopo.

Ngoma-Leslie, A. (2004, September). *Irohin: Taking Africa to the classroom.* A publication of the Centre for African studies at the University of Florida. Retrieved from http://www.clas.ufl.edu/users/aleslie

Nkosi, B. M. (2012). Understanding and exploring illness and disease in South Africa: A medical anthropology context. *International Journal of Humanities and Social*

Science, 2(24), 84–93.

Nxumalo, C. T., & Mchunu, G. G. (2017). Exploring the stigma related experiences of family members of persons with mental illness in a selected community in the iLembe district, KwaZulu-Natal. *Health South Africa Gesondheid, 22*, 202–212. Doi: http://dx.doi.org/10.1016/j.hsag.2017.02.002

Nyathi, P. (2001). *Traditional ceremonies of AmaNdebele*. Gweru: Mambo Press.

Parle, J. (2003). Witchcraft or madness? The Amandiki of Zululand, 1894–1914. *Journal of Southern African Studies, 29*(1), 105–132.

Passer, M. W., & Smith, R. E. (2011). *Psychology: The science of mind and behavior* (5th ed.). New York, NY: McGraw-Hill.

Peltzer, K. (1999). Faith healing for mental and social disorders in the Northern Province (South Africa). *Journal of Religion in Africa, 29*(3), 387–402.

Pietkiewicz, I., & Smith, J. A. (2012). A practical guide to using interpretative phenomenological analysis in qualitative research psychology. *Psychology Journal, 18*(2), 361–369.

Pietkiewicz, I., & Smith, J. A. (2014). A practical guide to using interpretative phenomenological analysis in qualitative research psychology. *Psychology Journal, 20*(1), 7–14. Doi: 10.1461/CPPJ.20.1.7

Pillay, A. L., Ahmed, R., & Bawa, U. (2013). Clinical psychology training in South Africa: A call to action. *South African Journal of Psychology, 43*(1), 46–58. doi: 10.1177/008214631247441

Prince, R. (1985). The concept of culture-bound syndromes: Anorexia nervosa and brain-fag. *Social Sciences Medicine, 21*(2), 197–203.

Roberts, K. T., Robinson, K. M., Topp, R., & Newman, J. (2008). Community perceptions of mental health needs in an underserved minority neighborhood. *Journal of Community Health Nursing, 25*, 203–217. Doi:

10.1080/07370010802421202

Rosenhan, D. L. (2016). On being sane in insane places. *Science, 179*(4070), 250–258. Doi: 10.1126/science.179.4070.250

Saad, M., de Medeiros, R., & Mosini, A. C. (2017). Are we ready for a true biopsychosocial-spiritual model? The many meanings of "spiritual". *Medicines, 4*(79), 1–6. Doi: 10.3390/medicines4040079

Sadock, B. J., Sadock, V. A., & Ruiz, P. (2015). *Kaplan & Sadock's Synopsis of Psychiatry: Behavioral Sciences/Clinical Psychiatry* (11th ed.). Alphen aan den Rijn, Netherlands: Wolters Kluwer.

Scheider, M., Docrat, S., Onah, M., Tomlinson, M., Baron, E., Honikman, S., et al. (2016). Integrating mental health into South Africa's health system: Current status and way forward. *South African Health Review, 13,* 153–163.

Schnittker, J., Freese, J., & Powell, B. (2000). Nature, nurture, neither, nor: Black-white differences in beliefs about the causes and appropriate treatment of mental illness. *Social Forces, 78*(3), 1101–1130.

Sehoana, M. J. (2013). *Exploring the perceptions of mental illness among Pedi psychologists in the Limpopo Province* (Master's dissertation). University of the Witwatersrand, Johannesburg.

Sehoana, M. J., & Laher, S. (2015). Pedi psychologists' perceptions of working with mental illness in the Pedi community in Limpopo, South Africa: The need to incorporate indigenous knowledge in diagnosis and treatment. *Indilinga – African Journal of Indigenous Knowledge Systems, 14*(2), 233–247.

Shinebourne, P. (2011). Interpretative Phenomenological Analysis. In N. Frost (Ed.), *Qualitative research methods in psychology: Combining core approaches* (pp. 44–65). Milton Keynes: Open University.

Skeen, S., & Lund, C. (n.d.). *Achieving the millennium development goals: Addressing mental health.* Mental Health and Poverty Project, University of Cape Town, S.A.

Skhosana, P. B. (2009). *The linguistic relationship between Southern and Northern Ndebele* (Doctoral dissertation). University of Pretoria, Pretoria.

Skhosana, P. B. (2010). *The (ama)Ndebele of Africa and their name '(ama)Ndebele'.* Retrieved September 08, 2016 from https://dspace.zcu.cz>bitstream>handle

Smith, J. A., & Osborn, M. (2007). *Chapter 4: Interpretative Phenomenological Analysis.* Retrieved from http://med-fom-familymed-research.sites.olt.ubc.ca/files/2012/03/IPA_Smith_Osborne21632.pdf&ved

Sorsdahl, K. R., Flisher, A. J., Wilson, Z., & Stein, D. J. (2010). Explanatory models of mental disorders and treatment practices among traditional healers in Mpumalanga, South Africa. *African Journal of Psychiatry, 13*, 284–290.

Sulmasy, D. P. (2002). A biopsychosocial-spiritual model for the care of patients at the end of life. *The Gerontologist, 42*(3), 24–33.

Sumathipala, S., Siribaddana, S. H., & Bhugra, D. (2004). Culture-bound syndromes: The story of dhat syndrome. *British Journal of Psychiatry, 184*, 200–209. Doi: 10.1192/bjp.184.3.200

Thompson, M. L. (2007). *Mental illness: Health and medical issues today.* Westport, CO: Greenwood Press.

Thompson, R. (2012). Looking healthy: Visualizing mental health and illness online. *Visual Communication, 11*(4), 395–420. Doi: 10.1177/1470357212453978

Thornton, J. A., & Wahl, O. F. (1996). Impact of a newspaper article on attitudes toward mental illness. *Journal of Community Psychology, 24*(1), 17–25. Doi: 10.1002/(SICI)15206629(199601)24:13.0.CO;2-0

Todor, I. (2013). Opinions about mental illness. *Procedia – Social and Behavioral Sciences, 82*, 209–214. Doi: 10.1016/j.sbspro.2013.06.247

Ukpong, D. I., & Abasiubong, F. (2010). Stigmatising attitudes towards the mentally ill: A survey in a Nigerian teaching hospital. *South African Journal of Psychology,*

16(2), 56–60.

Van Vuuren, C. J. (1991). Historical land and contemporary ritual: The innovation of oral tradition in understanding Ndzundza-Ndebele ethnicity. In *Oral tradition and innovation: New wine in old bottles*, edited by E. Sienaert., N. Bell., & M. Lewis. Durban: University of Natal, Oral Documentation and Research Centre.

Wilson, S, & MacLean, R. (2011). *Research methods and data analysis for psychology.* New York: McGraw-Hill.

Wong, D. F. K., Pui, H. T. K., Pearson, V., Chen, E., & Chiu, S. N. (2003). Changing health beliefs on causations of mental illness and their impacts on family burdens and the mental health of Chinese caregivers in Hong Kong. *International Journal of Mental Health, 32*(20), 84–98.

World Health Organization. (2004). *Prevention of mental disorders: Effective interventions and policy options.* A report of the World Health Organization, Department of Mental Health and Substance Abuse in collaboration with the Prevention Research Centre. Retrieved from http://www.who.int/mental_health/evidence/en/prevention_of_mental_disorder_sr.pdf&ved

World Health Organization. (2016). *International statistical classification of diseases and related health problems, 10th revision* (5th ed.). Geneva, Switzerland: World Health Organization Publications.

Yin, R. K. (2011). *Qualitative research from start to finish.* New York: The Guilford Press.

APPENDIX A: SUBJECT INFORMATION SHEET

Psychology

School of Human & Community Development

University of the Witwatersrand

Private Bag 3, Wits, 2050

Tel: 011 717 4503 Fax: 011 717 4559

Dear Sir/Madam

My name is Nonkululeko Gladness Mahlangu and I am a Masters in Psychology student at the University of the Witwatersrand. As part of my course I am required to complete a research project. My research focuses on exploring the perceptions of mental illness among the Ndebele community members, Middelburg, in the Mpumalanga Province. I would like to invite you to participate in this study.

Participation in this study is completely voluntary. You may withdraw at any time and there will be no negative consequence. Your participation would consist of a one-on- one interview (1 hour long) with me where you will be asked several questions based on the topic mentioned above. You may decide to not answer some of the questions. No identifiable information will be used. You will be referred to using a pseudonym such as participant 1, participant 2, etc. There will be audio tape recordings during the interview and these will be kept safely and upon completion of the research. There are no risks and benefits within the study. The findings of the study will be made available to the participants once available on request. Feedback will take the form of a one to two page summary sheet that outlines the study and its findings.

Should you feel you would like to talk to someone after the interview or you know of someone who may need help, please contact: LifeLine at 0861 322 322.

If you would like to enquire more about the study you are welcome to contact my supervisor or I. Our details are provided below.

Your participation in this study will be highly appreciated. Please detach and keep this sheet.

Nonkululeko Gladness Mahlangu

0636366469

gladness.mahlangu12@gmail.com

Supervisor: Sumaya Laher

(011) 717 - 4532

sumaya.laher@wits.ac.za

APPENDIX B: CONSENT FORM (INTERVIEW)

I, _____ consent to being interviewed by Nonkululeko Gladness Mahlangu, for her study exploring the perceptions of mental illness among Ndebele community members of Middelburg. I understand that:

- Participation is completely voluntary.
- I may withdraw from the interview at any time for whatever reason.
- I may refrain from answering any questions.
- There are no risks or benefits associated with this study.
- The information provided will be kept and dealt with in a confidential manner.
- No information that can identify me will be included in the research report
- I will be referred to using pseudonyms / an anonymous name (Participant 1, 2 or 3).
- I am aware that the results of the study will be reported in the form of a research report for the partial completion of the Masters in Psychology by coursework and research report.
- The research may also be presented at a local/international conference and published in a journal and/or book chapter.

Signed: _____

Date: _____

APPENDIX C: CONSENT FORM (RECORDING)

I, _____ give my consent for my interview with Nonkululeko Gladness Mahlangu to be recorded for her study exploring the perceptions of mental illness amongst the Ndebele culture. I understand that:

- The audio recordings will be confidential and will only be accessed by Gladness and her supervisor.
- The audio tape recordings will be stored for the duration of this study in a locked cupboard at the university, thereafter they will be destroyed.
- The transcripts will be stored on a password protected computer at the university to facilitate further research.

Signed: _____

Date: _____

APPENDIX D: INTERVIEW SCHEDULE

Introduction

Hello. I am Gladness Mahlangu, a Masters student at the University of the Witwatersrand. I am conducting a study on the Ndebele community members' perceptions of mental illness, and I appreciate your participation.

Before beginning with the interview, I would like to assure you that everything you say during this interview will be confidential, and only my supervisor and I will have access to the tapes and transcripts, which will be later destroyed. Although I know who you are, confidentiality will be maintained by not disclosing any information that is of a personal nature in the report. I will be assigning a pseudonym or an anonymous name to your information in the report, which will keep you anonymous. I would like to remind you that you have the right to withdraw from the study at any time during the interview. You also have the right to refrain from answering any question should you wish to do so, as some aspects of the questions may prove to be sensitive in regards to the study. A feedback summary of the study and its findings were provided to you upon request.

Contextual Questions

1. May you kindly tell me about your background, where you were born and where you grew up?
2. Please elaborate on your general upbringing, and experiences of growing up in the community.
3. Tell me about the Ndebele people and the Ndebele culture.
    - How did the Ndebele tribe come about?
    - What are the important aspects of the Ndebele culture?

Understanding mental illness

4. How do you think health and illness is understood by the Ndebele culture?
5. How do you think mental health is understood by the Ndebele culture?
6. What are your thoughts regarding mental illness?

Etiology of mental illness

7. In Ndebele culture, what are the beliefs regarding the causes of mental illness?
8. What do you believe the cause of mental illness to be?
    - Kindly elaborate on how you came about to know this.
9. How are spiritual illnesses understood in Ndebele culture?

Treatment of mental illness

10. What treatments are suggested for illness in the Ndebele culture?
11. What treatments are suggested for mental illness in the Ndebele culture?
12. What treatments do you believe would be effective for those who have mental illness?
13. Kindly give me an example on a mental illness case, or a story in the community, or within your family, friends, or personal case, you have experienced, or heard of. Please tell me about how the illness was diagnosed, what the perceived cause/s was/were for the mental illness and how it was treated.
14. Is there anything else you wish to add to the interview?

Thank you for participating in this study!