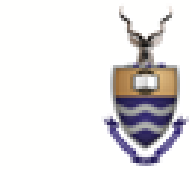

UNIVERSITY OF THE WITWATERSRAND

School of Human and Community Development

Discipline of Psychology

NARRATIVE ACCOUNTS OF MENTAL ILLNESS BY OLDER VILLAGERS IN LIMPOPO

Mohlale Sunday Paledi

1423286

Supervisor: Professor Hugo Canham

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A research report submitted to the School of Human and Community Development, Faculty of Humanities, University of Witwatersrand, Johannesburg, in partial fulfilment of the requirements for the degree Master of Arts in Community-based Counselling Psychology by coursework and research report.

Declaration

I, Mohlale Sunday Paledi acknowledge and accept that plagiarism in the form of using someone else's work and presenting it as mine is wrong and unacceptable, accordance with University of Witwatersrand's rules. Therefore, I declare that,

- The presented thesis (**Narrative accounts of mental illness by older villagers in Limpopo)** is my own and unaided work.
- I have appropriately acknowledged all the sources used in this thesis.
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- I am aware that should there be a belief that I failed to acknowledge the source (s) of the words/phrases/words in my thesis and, or that this is not my own unaided work, the University of Witwatersrand may take a disciplinary action against me.

Date: June 2021

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ABSTRACT

Currently, conceptualisations and meanings of mental illness are deeply rooted in Western models of mental health. Mental illness is a socially constructed concept that is not isolated from a particular historical context and is mostly informed by societal and cultural beliefs. Indigenous elders and their stories and knowledges about mental illness are often not included in literature. For this reason, the aim of this research was to understand how older villagers in Limpopo province make meaning of mental illness using a narrative approach rooted in decolonial and narrative theory as theoretical frameworks underpinning the study. Convenience and snowball sampling were utilized to draw ten participants over the age of 60 years in Limpopo within two villages located in the Greater Sekhukhune district. Narrative thematic analysis was used to analyse data derived from semi structured interviews. The findings of this research suggest that elders in Limpopo contribute significantly to their communities to maintain mental health as well as to manage mental illnesses that may arise. Mental illness was found to be associated with madness which was understood to manifest in the form of abnormal behaviours. Moreover, treatment towards people with mental illness was dependent on how the community made sense of particular people's illness. Furthermore, four causes of mental illness were identified as follows: witchcraft, stress, food, and the abuse of substances. In addition, the research found that even though indigenous modes of healing are predominantly used, Western and integrative healing systems were acknowledged by the participants. From the findings, it is evident that conceptualisations and meanings of mental illness in the villages of Limpopo are not solely traditionally African or Western. In the narratives, culture, religion and lived experiences informed how older villagers heal and make meaning of mental illness. Overall, the study highlighted the need for extensive local research that would enrich policy makers, scholars, researchers, and health practitioners with knowledges about mental illness and health as understood by the native people which could increase the effectiveness of multiple healing systems.

Key words; *mental illness, elders, narrative theory, decolonial theory, stories*

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CHAPTER ONE

1.1 Structure of the thesis

This thesis comprises of seven different chapters. The first chapter presents the following: background information on mental illness, the research problem, demographical information on Limpopo Province where the study was conducted, and the rationale for this research. In addition, the first chapter includes the research's aims, objectives and questions that were pursued as well as the key concepts which inform the study. In the second chapter, a literature review on mental illness is presented. In the third chapter, narrative and decolonial theories that formed part of the theoretical framework for this study are outlined. The fourth chapter presents the research design and the methodology employed. This chapter also discusses data analysis, participants' characteristics, data collection, sampling, ethical considerations, and reflections on my positionality. In the fifth chapter, the findings of the research are presented, and the discussion of the findings follows in the sixth chapter. In the seventh chapter, the conclusion, implications, recommendations, limitations and strengths of the study are outlined. The ethical clearance certificate for the conduct of this study, consent forms, information sheet and interview schedule used in the data collection are attached as appendices.

1.2 Background and orientation of the study

1.2.1 Introduction

Traditionally, there has been a greater emphasis on physical health as compared to mental health. The consequence of this is that mental illnesses are generally neglected (Wickstead & Furnham, 2017; Jorm, 2012). Recently, while mental health has been given more recognition, the conceptions surrounding mental illness are mostly oriented towards biomedical understandings. People's conceptions regarding meanings, treatments, origins, and languages of psychological distress are often dominated by the biomedical or Western model of mental illness. However, biomedical narratives do not represent all people's lived experiences. Alongside Western conceptions of mental illness, there exist traditional or indigenous understandings of illness (Jorm, 2012). Hence, Clancy et al. (2015) state that the meanings of mental illness ingrained in everyday social practices may differ from scientific and clinical understandings of mental illness.

The prevalence of mental illness is a global concern because it poses negative consequences for individuals, families, communities, and national economies (White & Casey, 2017). Globally, about 11% of people have mental illness (World Health Organisation, 2012). Furthermore, it is reported that in South Africa, about 17 million people are dealing with mental health problems while one third of the population has mental disorders. However, many are reluctant to get help (Sokhela, 2016; World Health Organisation, 2012). Rural based Africans are no less affected by mental health challenges (World Health Organisation, 2012). They often make meaning of mental health in different ways as compared to the dominant biomedical frame (Mbiti, 2015). Consequently, mental health is sometimes understood through multiple lenses concurrently. In various African societies, mental illness is predominantly attributed to witchcraft, incomplete or neglected family and ancestral rites as well as to supernatural causes (Sokhela, 2016). For instance, in largely rural provinces such as Eastern Cape, Mpumalanga, Limpopo and Kwa Zulu-Natal; ancestors, witchcraft, cosmological and other spirit forces are sometimes implicated in the ways in which particularly older people make meaning of mental illness, psychological distress, and misfortune. Another example is a place called Helena which is also called "Tulo Yabaloyi" (place of witches) in Limpopo where a community of displaced people were forcibly moved from their communities because they were perceived as people who brought misfortune and illness to others through witchcraft (Leff, 2014). This may illustrate how powerful the concepts of witchcraft and spiritual forces are, and what meanings they carry for some people. Mental illness and other illnesses are often believed to be caused by misfortune and witchcraft. Thus, this might explain why most people tend to seek help from traditional healers.

According to Mkhize and Uys (2004) and World Health Organisation (2001), most people consult traditional and religious healers simultaneously or before they consult a Western trained mental health practitioner. Western modes of healing are often perceived as foreign and looked upon with stigma and doubt while healing by traditional and religious healers is considered local, indigenous, and holistic (Gqibitole, 2017). Traditional healing practices generally target the body, soul and mind and consider the person within their broader sociocultural context (family, religious, cultural and community contexts) (van der Zeijst et al., 2020; Ross, 2008). Traditional healing practices are prevalent because of the perceived benefits they offer to people, one of those benefits being that they are affordable. Due to their high prevalence, scholars are increasingly conducting studies on indigenous/traditional understandings and meanings of mental illness (van der Zeijst et al., 2020; Ally & Laher, 2008;

Mzimkulu & Simbayi, 2006; Yen & Wilbraham, 2003). This study will therefore give attention to the shifting meanings of mental illness by looking at the key questions raised around how rural older people make meaning of mental illness and the ways that narratives of cultural and religious beliefs intersect with manifestations of mental illness.

1.2.2 Research problem

Developing countries such as South Africa are faced with several health issues and mental illnesses are predominantly one of them (Ally & Laher, 2008). Mental illness does not only impact the diagnosed person, but its impact extends to families and communities a person is embedded in. It is evident that it is not only the individual's well-being and mental health that is affected when a person is ill, but also the community's well-being more generally (Sehoana, 2015). Narratives and conceptualisations of mental illness or psychological distress in communities are influenced by culture and religion which consequently plays a significant role in how treatment is sought and received (Reupert & Maybery, 2010). However, certain issues surrounding mental health such as manifestation of psychological distress and treatment seem to have been addressed mostly from Western psychology standpoint. For example, Western models such as the Diagnostic and Statistical Manual of Mental Disorders (DSM) are currently used to classify symptoms of mental illness (American Psychological Association, 2013). Recently, there has been some developments and inclusion of culture-bound symptoms in the DSM (Watters, 2010). This suggests that the dominance of Western perspectives in the world often disregards or dismisses alternative explanations of mental illness present in diverse sociocultural contexts.

There is nevertheless a prevalent belief among Western mental health professionals that all mental illnesses listed in the DSM are all universal (Sehoana, 2015). Thus, this assumes that mental disorders manifest in the same way across all cultures and does not consider the impact of cultural or religious beliefs in how people understand and make meaning of these disorders and ways of being (Sue et al., 2006). Furthermore, Western beliefs and standpoints perceive the person as being personally responsible for his or her own well-being and problems (Watters, 2010). The assumption underlying a universal discourse of psychological wellbeing is that the diagnostic manual applies across cultures. This produces a hegemonic understanding of distress and wellbeing as medical insurance, and treatment are only justified when they are validated by the diagnostic manual. This means that ways of being that are not validated by the American

Psychological Association and organised psychiatry are marginalised (Watters, 2010). This might be problematic in multicultural societies or contexts with more traditionally bound cultures apparent in culturally diverse settings like South Africa. In all cultures, culture influences the understandings and meanings of illness as well as the pathways to healthcare that people in that specific culture choose to follow. Also, some studies have argued that culture influences how mental health or health and well-being is understood in relation to the self and the whole collective group (Gergen, 2015; Saravanan et al., 2008; Chong et al., 2007;). Thus, there is a need for understandings and meanings of mental illness which are socially determined by the broader historical and cultural contexts in which people are situated.

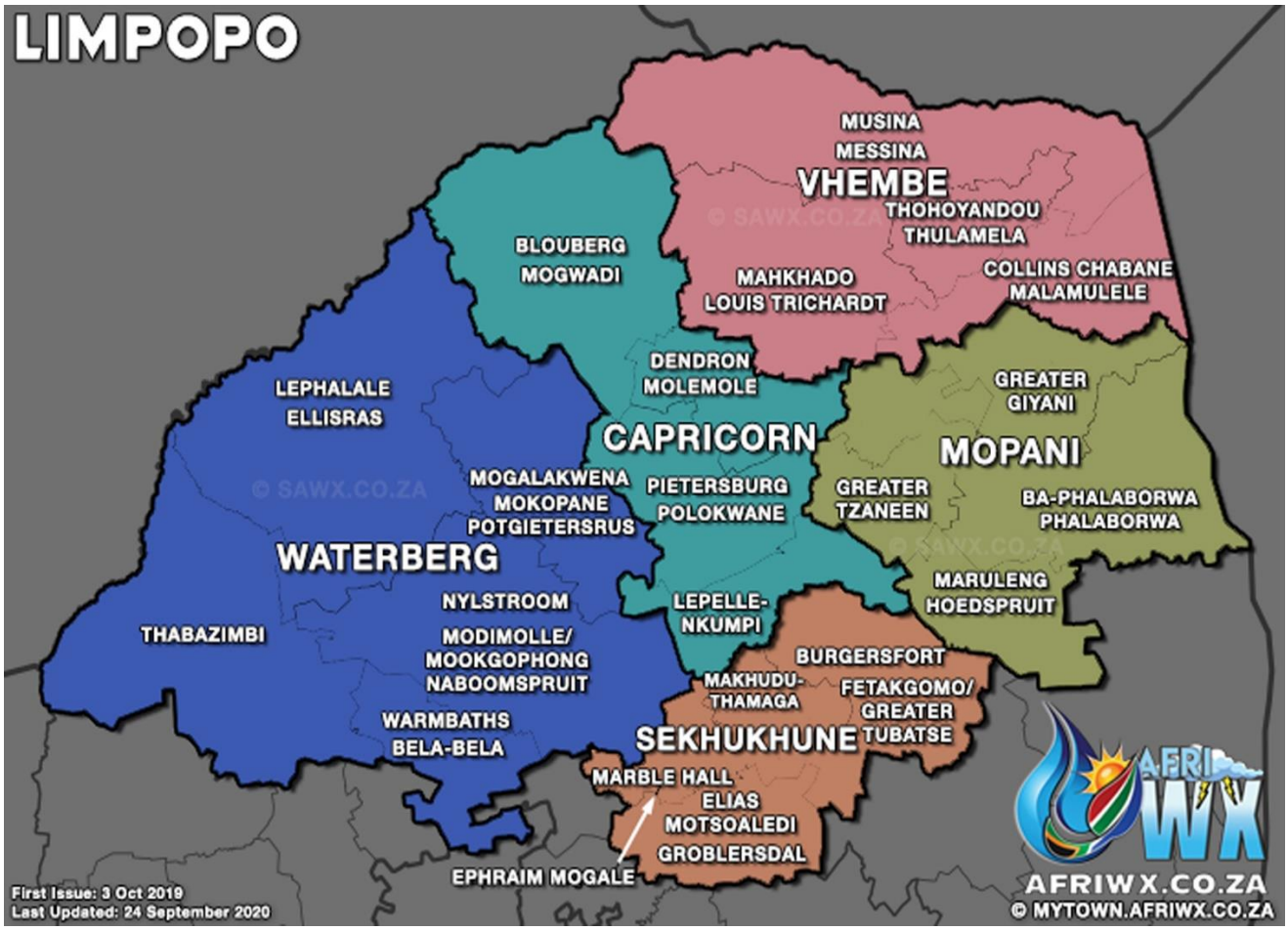
1.2.3 Context of the study

The study was conducted in two villages of Limpopo province, South Africa. Limpopo was formerly called the Northern Province. According to Makhura (2002), the province of Limpopo is situated at the North-eastern side of South Africa. The province shares international borders with Botswana, Mozambique, and Zimbabwe (Makhura, 2002). Limpopo is reported to be the fifth largest province of the nine provinces in South Africa. It is made up of five districts namely, Greater Sekhukhune, Capricorn, Mopani, Waterberg, and Vhembe. It is measured to be approximately 125 755 square kilometres (Statistics South Africa, 2016; Cadman, 2007). The map of South Africa (*figure 1*) and the province of Limpopo (*figure 2*) are shown below.

Figure 1: Map of South Africa

Source: extracted online from National online project (n.d)

Figure 2: Map of Limpopo Province



Source: Extracted online on About South Africa (2020)

Statistics South Africa (2016) reported that the population size in the province was recorded to be about 5 7999 090 6. The majority of Limpopo's population is mainly made up of three major tribes namely the Pedi, the Venda and Tsonga tribe (Statistics South Africa, 2016). Hence, the common languages predominantly spoken in the province are Sepedi, Tshivenda, and Xitsonga. However, the most commonly spoken language in the province is Sepedi (Statistics South Africa, 2016). The language is spoken particularly in the Greater Sekhukhune district which is where the research was conducted. Pedi people form part of the Sotho tribe (Sehoana, 2015). According to Monnig (1967), the name "Sotho" simply means "batho ba baso" which translated into English means black people. Similar to the origins of most Bantu communities in South Africa, the Sotho people's roots are traced back from Central and West Africa (Sehoana, 2015). There are currently different categories of Sotho people; the Western, Southern and the Northern Sotho groups. The Pedi people belong to the Northern Sotho group.

It has been argued that even though there is lack of research on Pedi culture and their narratives as well as perspectives of mental illness, traditional practices and beliefs are widely followed among Pedi people (Sehoana, 2015). Pedi people mostly use culture to articulate their experiences and narratives about how the world is and ought to be as well as about what matters. They have diverse beliefs which include witchcraft, Christianity, and ancestors/gods ("badimo") and share the African perspective that the community is the basis of health. They are likely to believe that the person who is mentally ill is "mad", bewitched, cursed, or has an ancestral calling (Sehoana, 2015). While there are a number of studies that have been conducted in different settings in the South African context, one in Limpopo found that mental illness in the province is narrated or understood and treated through cultural lenses (Havenaar et al., 2008). However, in some instances the cultural beliefs of the community motivate stigma towards the mentally ill (Mavundla et al., 2009). This leads to victimisation and discrimination of those with mental illness.

There are major hospitals that are supported by local clinics to service the health care needs in each district of Limpopo. However, these are usually overcrowded and inaccessible due to lack of resources. Lack of access to mental health services is quite common among the general population (Sehoana, 2015). While the Department of Health aims to make mental health services available and accessible to the community in all district hospitals in Limpopo, it has failed to reach the vast majority of people (Department of Health and Social Development, Limpopo, 2008). Additionally, the mental health programme developed in 1977 in South Africa has attempted to make mental health services available and accessible to rural communities in Limpopo and across the country (Sehoana, 2015; Mugabe, 1998). However, it has been argued that there is still little to no acknowledgement of existing indigenous cultural modes of healing and understandings of mental illness in the province (Mufamadi & Sodi, 2010). In addition, many people in the province mostly opt for traditional and religious healing systems which are perceived as affordable and easily accessible (Sehoana, 2015). Traditional authorities such as traditional healers, queens and chiefs play significant roles in land administration, community health and implementing or developing customary laws in the rural areas of Limpopo (Sekgala, 2017; Brynard &Musitha, 2011).

Limpopo is considered to be largely rural because poverty is high in the province as compared to other provinces in South Africa and the poor mostly reside in rural areas (Limpopo Provincial Treasury, 2012). A survey conducted in 2018 by Statistics South Africa reported that adult poverty in Limpopo was at 65,7 percentage (Statistics South Africa, 2018).

Considering that most of Limpopo is rural, living conditions in the province are reported to be substandard (Gyekye & Kyei, 2011). Service delivery continues to be a challenge as about 75,5 percent of people in the province do not have access to drinkable water as they fetch water from unprotected wells, ponds, rivers, cisterns, and streams (Statistics South Africa, 2016). Additionally, refuse removal presents as a significant problem in Limpopo with only 22 percent of the population reporting to have access to waste collection services (Statistics South Africa, 2016). Additionally, according to Statistics South Africa (2016), approximately 84 percent of the households have stable access to electricity.

1.2.4 Rationale for the study

There have been calls for comparable and cross-cultural studies to understand the origins, consequences and meanings of mental health and illness (van der Zeijst et al., 2020; Bartholomew, 2016; Rutz, 2001; Hopper & Wanderling, 2000). To respond to this demand, we need to explore the insights and differences in the meanings and knowledges of mental illness across cultures in society. Thus, this study explored the meanings of mental illness by using a narrative approach. In order to enrich our understanding of how people make meaning of mental illness in the rural context of Limpopo, this research gathered the stories of older villagers. This was understood to help to shed light on how they create their worlds, what they consider salient, and how they think about the psychosocial. This research assists with identifying various knowledges that people have about mental illness that go beyond biomedical understandings. This could improve the quality of mental health services through integrating various health care systems and meanings of mental illness present in diverse societies (Alegrıa et al., 2018; Corrigan & Watson, 2001). According to Dein (2003), it is important that mental health practitioners gain knowledge not only about Western healing systems and conceptualisations of mental illness but also about traditional and religious healing systems used by various cultures in diverse contexts. This research might inform policies to understand mental illness contextually and historically at a community-level as well as assist with establishing successful practices in the mental health field.

Additionally, this research recognizes that qualitative and quantitative studies have been done on people's experiences, beliefs, attitudes, perceptions of mental illness focusing mainly on the younger population (Clancy et al., 2015; Futeran & Draper, 2012; Cummings & Kropf, 2011). However, the literature mostly reveals the assumptions of academics and healthcare professionals about older people's decisions to seek mental health services and their voices are

often absent in the research. Therefore, this study aims to explore understandings of mental illness among older villagers from rural communities in narrating their own stories of how they make meaning of mental illnesses and health in general. For older people, a narrative approach can help them to organize their experiences, assign meaning to those experiences, inform modes of identity and being, guide action and challenge present dominant narratives in society (Randall et al., 2015; Phoenix et al., 2010; Fraser, 2004). Since traditional conceptions about mental illness are culture-bound, older people are best suited for this research as they play a role as storytellers as well as carriers of knowledge, traditions, and culture in the society especially in indigenous traditions worldwide. Also, elders are often the medicine people, sacred knowledge keepers and bind communities together relationally and spiritually (Simpson, 2013; Sium & Ritske, 2013).

Furthermore, by focusing on narratives, the study explores how stories are structured, how they work, who produces them and by what means as well as how narratives are accepted, contested, or silenced (Esin et al., 2014; Sium & Ritskes, 2013). While the study remained open to participants' own understandings, it anticipated that the supernatural world which may include witchcraft will be an important lens to understanding psychological distress and wellness. These concepts are often not openly discussed even though they have some implications on the manifestation and management of mental illness. In addition, the research seeks to contribute to current ongoing dialogue about cultural beliefs and mental illness as well as provide a platform for further discussion on the subject. The study hopes to lead to a shift away from focusing on one model that is based on Western culture and moving towards adopting a holistic approach to deal with these issues especially in multicultural societies such as South Africa (Yew-Siong, 2021; Swartz, 1985). Moreover, the study was open to understanding the manifestations of mental illness as a result of conflicts between the people, others (including ancestors, those who are alive and spirits) and the non-material forces present in African societies (Asante, 2003; Mkhize, 2003; Mbiti, 1990).

1.2.5 Research aims, objectives and questions

Aims of the study

This study aims to explore knowledges and meanings of psychological distress and healing systems from the perspective of the narratives of older villagers.

Objectives

The objectives are to:

- Explore how older villagers of Limpopo make meaning of mental illness.
- Identify existing systems of healing for mental illnesses among older people in rural villages.
- Explore local knowledges about mental illness and how they influence the way older villages in Limpopo make meaning of mental illness and healing practices.

Research questions

Three research questions that will be addressed are:

- How do older villagers in Limpopo make meaning of mental illness?
- What do the narratives of older villagers in Limpopo reveal about their knowledges of mental illnesses?
- What are the various health care healing systems that older villagers in Limpopo seek help from for mental illness?

1.2.6 Definition of key concepts

- ***Mental illness:*** a consistent pattern of dysfunction or present distress in an individual significantly associated with high risk of death, pain, suffering and loss of freedom (American Psychological Association, 2013). The concept mental illness may be used interchangeably with psychological distress in this study to convey the same meaning.
- ***Older people:*** refers to the people who have surpassed the age of 65 years. People who are aged 65-74 years of age and older are regarded as the "early elderly" while those who are 75 years older are referred as the "late elderly" (World Health Organisation, 2010).
- ***Narratives:*** refers to stories about things that have occurred or are happening to people etc. Stories contain a series of events occurring over or within a time period, can be short or very long (Berger, 1997).

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

In this chapter, the literature on the historical views of mental illness is reviewed. African and Western psychology is differentiated. The following section will also focus on the common African cultural and Western views regarding the causes, understandings, and treatment of mental illnesses.

2.2 Genealogies of mental illness

It is justified to assume that mental illness has always existed from the beginning of time. However, mental illness only came to be recognized as a disease towards late 18th century (Mashamaite, 2015). The development of Western psychiatry began with German psychologists and neurologists of the mid-to-late nineteenth century. They were known for their focus on the description of abnormal behaviour and causes of mental illness (Barlow & Durand, 2009; Miller, 1994). However, the history of psychiatry in the South African context can be traced back to the first settlement by Europeans in 1652. Around the early 19th century, psychiatric diagnosis was non-existent in the country and those who were mentally ill with no physical cause were labelled as “lunatics”, “mad” or “insane”. They were mainly thought to be possessed by demons or bewitched (Gillis, 2012). It was only around the late nineth century when Kraepelin was influenced by the work of Hippocrates to develop a comprehensive classification of mental illnesses which led the path for the World Health Organisation’s implementation of the DSM, which has been revised many times as well as the International Classification of Diseases (ICD). The ICD and DSM are currently used as diagnostic models for classifying mental disorders by mental health practitioners (Mashamaite, 2015).

The World Health Organization has historically played a major role in influencing international development and health. However, mental health was relatively marginalized. The World Health Organisation (2001) conducted a report on the statistics of mental disorders and the extent to which they were of global concern. The report resulted in policy shifts which emphasized access to, and availability of mental health services through integration of community-based services (World Health Organisation, 2001). However, mental health interventions and preventions continue to be allocated small budgets and insufficient funds (Lovell et al., 2019). Historically, global health policies prioritised or targeted diseases such as

tuberculosis, the HIV/AIDS, and malaria epidemics and were funded by prominent programs such as the Global Fund, and this continues to this day (Eboko, 2015). It is evident that mental health has long been side-lined and this has led to some critiques that mental health remains marginalised while physical health takes priority. Secondly, global mental health is critiqued for pathologizing economic and social problems as well as conflicts into individual pathologies of mental illness (Lovell et al., 2019). For instance, this has occurred in the invention of "victimology" and post-traumatic stress disorder (Fassin & Rechtman, 2009; Young, 1997). In addition to this marginalisation, Western treatments, diagnoses, and interventions in underdeveloped and developing countries do not acknowledge communities' own cultural and historical contexts (Watters, 2010; Summerfield, 2008). This perpetuates (neo) colonisation on non-Western contexts and people as well as psychiatric imperialism which overlooks the 'local culture' (Fernando, 2017). The existing knowledge in psychiatry is said to be biased and ethnocentric, as such that because it passes as universal and the truth, it holds the power (Fernando, 2017; Marsella & Yamada, 2000).

Western psychology and psychiatry have the power and privilege of denoting what is acceptable in relation to mental health conceptualisations and understandings (Bemme, 2019). Those who do not have that power are marginalised as their views are consigned to irrelevance. Hence, we need mental health care interventions and models that are developed, tested, and built in underdeveloped and developing countries especially in sub-Saharan Africa so that the interventions are relevant and applicable to local cultures (Bemme, 2019). For the last few decades, Western psychology, and psychiatry along with other mental health sciences and professions (i.e., sociology, anthropology, social work, and public health) have increasingly recognised the significance of cultural factors in conceptualisations of mental illness and health (Marsella & Yamada, 2000). However, mainstream psychology continues to be a predominantly Euro-Americentric Western science which was shipped to Africa and imposed on Africans through the American diagnostic manual (Watters, 2010). As a result, to date there are no dominant psychological theories developed purely from African perspectives (Maca-Meyer et al., 2003). It is difficult to find an overarching viewpoint on indigenous or traditional concepts embracing the core elements of an African psyche.

Furthermore, for us to understanding mental health and illness we need to trace the genealogies of the phenomena. Ecks (2016) explains that undertaking the task of tracing these genealogies means we do not only look at the present state within the networks of mental health but also what is excluded in these networks. The genealogical perspective rejects essentialism which

discerns the uncertainties, fragilities, and contingencies through which networks of power, practice, values, and knowledge not only emerge but also shifts (Lovell et al., 2019; Foucault, 1977). Genealogies rejects the conception of absolute truths and denotes multiple traces of many practices, social and cultural formations as well as ideologies that worldwide topics of interest such as mental healthcare and mental illness have been managed, co-produced and at times resisted (Nietzsche, 2013). This may explain why mental illness cannot be explained from only the biomedical perspective.

2.3 Distinguishing between Western and African psychology

Alias (2010) defines psychology as a scientific discipline that studies human behaviour and mental processes. However, this definition has been contested because it is considered to be incomplete as it disregards the significant concepts of ubuntu (humanity), the soul and beliefs which influence one's mental processes and behaviour (Alias, 2010). African psychology which formally began around the 19th century is considered to attend to this contestation/criticism. Humanity is central in African psychology, however Nyowe (2015) asks "what is African psychology for, who is it for?" (p.96). Long (2016) argues that this question reinforces the unhelpful obsession of what it means to be 'African' which is a fundamental barrier to Africanization of psychology. More often, definitions of 'the African' are orchestrated through culturally and racially charged lenses which exclude those who are not black and makes it difficult for them to position themselves in the field (Long, 2016). To be clear, African psychology is linked to but not identical to psychological work done by black scholars. This suggests that any work that is ideologically problematic and works against Africans would not be recognized as African psychology. According to Ratele (2017) "all of psychology done in and for Africa, about Africans, by Africans as well as non-Africans working on Africa is African psychology" (p.1). Ratele (2017) argue that African psychology is an informed and systematic study of the complexities of culture, experience, and human mental life in the African world. It is pluriversal, multilingual and multicultural (Nyowe, 2015). Ratele (2017) discusses four psychologies to give a broader distinction between African and Western psychology.

Ratele's (2017) four psychologies are not subdisciplines of psychology, such as developmental, psychopathology, social, personality, and cognitive psychology nor do they resemble categories of registration of the professional associations of psychologists such as counselling, clinical, educational, research or industrial psychology. However, these psychologies will be

found in the subdisciplines of psychology (Ratele, 2017). The first orientation is African psychology recognized as Western psychology in Africa. This psychology influences what is taught, most theoretical explanations, research approaches and what is published as well as the analyses that govern what the majority of counsellors and psychologists apply in their line of work. The psychology in Africa orientation (Western psychology) is fundamentally based on the premise that psychology as a discipline ought to be scientific, universal, value-free, objective, and apolitical. The main advantage of this orientation is that it perfectly aligns with mainstream psychology as understood and practiced in Europe, the United States, and other parts of the globe (Ratele, 2017). However, scholars such as Cooper (2013) criticize it, arguing that it is "a pathetic clone" of hegemonic psychology from Europe and the United States.

The second orientation is cultural African psychology which is concerned with spiritual and cultural phenomena and emphasizes the significance of shared African languages, values, beliefs, philosophies, worldviews, and knowledges (Ratele, 2017). It denotes that African psychology should start with an examination of Africans' languages, worldviews and philosophies which inform how African people experience the world (Mkhize, 2004). It takes into account Buntu/Botho (personhood) as understood in traditional African thought as significant in studying psychology and psychiatry in the African context (Nwoye, 2017; Mkhize, 2004). In this orientation, psychology is understood as means to organise the way people speak, understand, and see the themes of psychiatry and psychology as cultural subjects rather than favouring Western values and presuppositions. In a world that is dominated by Western culture and ideas, those who are able to master Western psychology at an advanced level as a cultural tool are greatly rewarded. Cultural African psychology sets out to reject cultural domination in mainstream psychology as means to reaffirm the humanness of Africans, however it has been criticized for not being critical of injurious and prevalent African cultural practices (Ratele, 2017).

The third orientation is critical African psychology which questions the workings of knowledge and power in psychology and how they relate to Africa and its people (Ratele, 2017). It focuses on contemporary and historical contestations around culture and between the African and Western frameworks. It critiques the overdependence on Western theories and the tendency to engage African ideas and theories only when they have been re-imported from and endorsed by Western contexts (Ratele, 2017; Painter et al., 2013).

The last orientation is psychological African studies which argues that an appreciation and engagement of the potential development and contribution of psychological African studies begins with understanding that core disciplines in African studies never included psychoanalysis or psychology. In contrast to the first orientation (Western psychology) which is prevalent and practiced in Africa, it is rare to find what is referred to as psychologically inclined African studies (Ratele, 2017). This is problematic because most of Western psychology studies perceive the world as made up of separate distinct individuals. This becomes problematic if the perception remains unchanged. There should be room left for Western psychology to perceive individuals as a part of a collective that include others, as is the case in most African cultures where people do not function on their own (Ratele, 2017). Therefore, to develop situated psychological African studies, it is necessary to "unlearn" and abandon some of the ways in which Western psychology understands and perceives people. We need to seriously consider non-psychological studies on religions, languages, histories, cultures, and societies in Africa.

The distinctions between African and Western are apparent and both orientations are wanted and needed. Western psychology is just as important as African psychology because most psychological concepts used today come from Europe and the United States. However, we need to think about what African studies might contribute to critical psychology as well as what critical psychology might contribute to African psychology and studies, while simultaneously continuing to make significant contributions to global knowledge (Nyowe, 2015). To think that African psychology had white fathers is often perceived as comical. However, this is to acknowledge the fact that African psychology was breed as a result of the lethal intimacy between the colonial and the indigenous (Ratele, 2017). To state that psychology as a discipline in the African context has been influenced by Western or European morals, notions and presuppositions is not to be interpreted and understood as arguing for expunging all Western ideas. Nwoye (2015) argues for a universal psychology which comprises of pluriversal psychologies which are culturally and religiously inclusive instead of a dominating Western centred perspective of psychology. This will guarantee that psychological concepts developed in both pre-colonial Africa and Western context coexist, also equally participate in psychology textbooks and curricula in Euro-American and African research institutions (Nwoye, 2015).

2.4 Mental illness: explanatory models

Explanatory models make reference to the various ways that people make meaning and explain their illness or symptoms, especially in relation to how they perceive the causes and healing of their illness. This involves how their illness affects not only them but their social environment and what they deem as appropriate healing system (s) for their illness (Bhika et al., 2012; Kleinman, 1977). Scholars have argued that cultural and religious systems of beliefs, practices and knowledges provide explanatory models for illnesses such as mental illness (Petkari, 2015; Jorm, 2000; Swartz, 1985). Explanatory models drawn from cultural and religious systems are taken from ideas about what constitutes the process of healing and illness as well as what makes up the world and the person. Western and traditional explanatory models of mental illness can potentially impact coping, expectations about the treatment, help-seeking behaviours, long-term consequences as well as stigmatisation of mental illness (Petkari, 2015; Sorsdahl et al., 2010; Swartz, 1985; Swartz, 1984). Mental health practitioners must be alert to the existing explanatory models so that they can understand that there are diverse ways of making sense of mental illnesses. Thus, being alert to various explanatory models of illness will enable practitioners to respect and understand diversity, offer effective support to their clients as well as encourage optimal engagement with clients (Bhika et al., 2012; Jorm, 2000; Swartz, 1985; Swartz, 1984). The explanatory models of mental illness help us to understand and acknowledge that people and societies are diverse, thus they will have their own ways of describing and understanding different mental illnesses (Bojuwoye & Sodi, 2010). For example, in most African countries, people form their interactions based on how they make sense of things not necessarily on how things are. Furthermore, studies conducted in African contexts have argued that African people often believe that most illnesses are related to supernatural causes which can be observed physically and spiritually (Leavey et al., 2016; Ezeabasili, 1997). In addition, a study conducted in Mpumalanga among traditional healers aimed to explore the existing explanatory models for mental illness in the province and found that illnesses, either physical or mental are usually attributed to the influence of witchcraft or ancestors (Sorsdahl et al., 2010).

2.5 Culture and mental illness

2.5.1 Defining culture

The concept of culture has occupied the minds of anthropologists and social scientists and continues to do so (Katan, 2018; Swartz, 1985). Culture involves the process and experiences of being as well as the rules about the society the person is situated in and how these are transmitted and experienced from generation to generation within a society. Culture is not static, it is forever changing over time with different circumstances (Katan, 2018; Swartz, 1985). It is through culture that people make meaning of their surroundings, their lives, and the whole world. Existing African cultures are complex and hybrid, encompassing of blacks, Indians, those of mixed descent, whites, and other categories of Africans (Nyowe, 2015). Cole (1992) states that humans can organize their environments and lives according to cultural meaning systems which are specific to the context they live in. Each culture perceives human nature in its own ways and terms. Cultures conceive of and produce knowledge about people, their functioning, their agency, morality, and development in line with the embedded cultural meaning systems existing in their contexts (Subudhi, 2014; Nsamenang, 1995). Culture plays a role in the expression, emergence, and healing of culture-specific syndromes such as *"mafufunyana"* (Matsumoto & Juang, 2016). Mental health and psychological distress are therefore understood within the cultural complex in which they are located in.

Most often mental illness is explained from a biomedical and ecological perspective considering biological factors such as chemical imbalances in the body, environmental factors such as poverty and psychological factors such as severe trauma. However, cultural factors are rarely accounted for. Culture often influences mental illness regarding the conception, perception, experience of symptoms, treatment, classification, recognition and labelling of mental illnesses (Subudhi, 2014; Ng, 1997). Furthermore, various scholars who conducted qualitative studies in South Africa and Asia have argued that in most societies; religion, supernatural, cultural, moralistic, and magical approaches to mental illness have existed for centuries (Laher & Khan, 2011; Ally & Laher, 2008; Ng, 1997). Laher and Khan (2011) state that religious beliefs are often equated with cultural beliefs. This often turns out to be the most significant determinant of how one perceives and understands mental illness. Similar to culture, religion which is guided by specific practices, activities and belief in some powerful God, has been argued to be complex and diverse (Dawes & Maclaurin, 2012). People may follow different cultures and religions depending on their context, upbringing and personal beliefs or

values. Both culture and religion advocate that spirit possession and witchcraft influence one's behaviour. Studies have shown that religiously and culturally a person may be observed as bewitched but could resemble the state of a person who is mentally ill (Karim et al., 2004; Morrison & Thornton, 1999). This suggests that there is a need to not only expand aetiological understandings, but to also integrate these cultural and religious understandings into diagnosis and treatment of mental illnesses (Horwitz, 2020). This might assist with understanding people in their own contexts.

2.5.2 Biomedical, cultural and religious definitions of mental illness

Currently, spiritual, religious and/or cultural conceptualisations of mental illness from non-Western cultures are understood merely as ways of coping with illnesses such as mental illness by Western models rather than as understandings and knowledges that are worthy of being studied further (Greenwood et al., 2000). Biomedically, mental illness is defined as a medical condition that disturbs a person's emotional, cognitive, mental, and social functioning in their daily lives (National Alliance on Mental Illness, 2011). Jorm (2000) found that majority of people in England do not fully understand mental disorders and what psychiatric terms mean as labelled in the biomedical framework. Instead, their understanding about the meanings, treatments and causes of mental illness were embedded in their cultural beliefs which varied from the biomedical model of mental illness. Thus, it is evident that all cultures have belief systems that influence how they define and make meaning of mental illness (Ussher, 2014). Most African societies equate mental illness to madness, demon possession and witchcraft (Kinyua & Njagi, 2013). Malawian societies deem someone to be mentally ill if they speak loudly with elders, are always alone and refuse to interact with their peers (Benduce, 1996). A study conducted in Malawi explored patients and carers' attitudes towards mental illness and found that participants would identify a person who is mentally ill as possessed and exhibiting abnormal behaviours (Crabb et al., 2012). In Zimbabwe, one is considered mentally ill if they unconsciously act foolish (Chavunduka, 1978). Other authors have stated that many people in underdeveloped and developing countries believe that mental illness is often caused by witchcraft and stressful life events which influences how they define illnesses (Leavey et al., 2016; Aina, 2008; Kadri et al., 2004; Srinivasan & Thara, 2001). Similar findings have been found in American, Somalian, and Chinese cultures (Stefanovics et al., 2016; Wynaden et al., 2005; Chien et al., 1994)

The concepts that various cultures use to define what mental illness is, may have differences and similarities to Western psychiatric terms. However, local expressions of mental illness should not be reduced to Western diagnostic and psychiatric categories (Carroll et al., 2004). It is difficult and perhaps impossible to fully grasp a coherent overview of how all diverse cultures use language around mental illness. For example, expressions such as Cudurada, dhimirka, Xanuunka dhimirka etc. are used by Somalians to express mental illness as the illness of the brain or mind (Johnsdotter et al., 2011; Mölsä et al., 2010). It can be challenging to translate terms that refer to specific behaviours in other cultures into other languages. The people in that culture will understand the meaning while an outsider will have difficulty understanding the meaning underlying the expressions when translated. While some terms might indicate presence of mental illness, it might not be the case with other terms. Furthermore, in most African cultures, the body, spirit, and mind are perceived as a whole, so it might not be common to describe or explain psychological distress in psychiatric terms (Passada, 2019).

Religious practices are sometimes associated with mental illnesses and health. For instance, religious beliefs play a significant role in how people with mental illnesses such as obsessive-compulsive disorder make sense of the illness (Schieman et al., 2013). It has been argued that in most cases the illness is attributed to fears of God, fears of sin etc. Additionally, a patient who exhibit psychotic symptoms may believe he is a religious deity, or the devil while one who is depressed may be overwhelmed with severe feelings of guilt, believing they has committed an unforgivable sin (Behere et al., 2013). However, this is not to suggest that religion promotes mental illness because people often turn to religion for healing, comfort and peace. A qualitative study conducted in South Africa among five to eight Muslim students utilizing focus groups found that Islam plays an important role in how mental health and illness are understood (Gibson, 2015). The study found that the participants understood healing, causes and meanings of mental health and illness through religious lenses. This suggests that Islam might follow non-Western pathways in understanding and healing mental illness. Additionally, Mohamed-Kaloo and Laher (2014) conducted a qualitative study in Johannesburg among Muslim general practitioners (GP) and found that in the Muslim community, there might be stigma associated with seeing a psychiatrist or psychologist. A study conducted in Ghana addresses this and argues for the need for a holistic way of understanding mental illnesses (Osafo, 2016).

There are many reasons why it is challenging to achieve professional consensus when attempting to define mental illness because of the disparities found between Western, traditional and religious definitions of mental illness (Mashaimate, 2015). Mashaimate's (2015) study found that traditional or indigenous healers in the Capricorn district of Limpopo may define and treat mental illnesses differently as compared to the biomedical framework. They often would say a person is bewitched or cursed when exhibiting abnormal behaviour. While Western definitions of mental illness focus primarily on the individual, intra-psychic causalities and biological aspects, traditional and religious definitions usually understand the individual as located within the broader community they come from. Moreover, the definition of mental illness is influenced by various factors including cultural influence, religion, historical context, level of education, and in some circumstances the level of scientific knowledge (Akomolofe, 2012; Njenga, 2007). For example, in most African societies lesbian and gay people are still perceived as mentally ill, because their sexual orientation goes against "nature" (Njenga, 2007). Therefore, it is fair to reason that the concept of what constitutes as mental illness is dynamic and may change from culture to culture, between religions, places, time to time and between generations. However, specific elements that are of universal significance for mental illness and health must be identified (Ryan, 2008). Thus, mental health practitioners should look beyond their preconceived ideas and own opinions about what constitute causes and definition of mental illness, to be able to acknowledge that it might not be the case with other people (Granello & Granello, 2000).

2.5.3 Elders as keepers and conveyors of culture

The world and our values are forever changing. However, the changes are not entirely the same or universal, they vary from place to place, and we get a glimpse of this change and the past by talking to elders (Gonzalez-Rico & Fuentes-Pineda, 2018; Grosz-Ngaté et al., 2014; Ayittey, 2010). Cultural and religious beliefs shape social norms and values and the role of older people. Elders play important roles in their families and the societies they live in; they undertake roles that are usually not performed by the younger generation (Eades et al., 2021). One of the distinct features present among elders is wisdom which is informal knowledge that enables them to play their roles as keepers of indigenous knowledge which can be about mental illnesses or something else (Kirmayer et al., 2011; Basset, 2009). Matobo et al.'s (2009) study which looked at how traditional initiation of boys and girls from South Africa and Lesotho comes about, stated that in communal practices and traditions indigenous elders are perceived as storytellers, educators, historians, healers, and language keepers of our societies.

Additionally, an older Western psychological study by Nixon (1962) emphasized that people through experience and growth reach emotional maturity. This could suggest that elders' experiences throughout time have afforded them emotional maturity and skills to guide subsequent generations. Through their stories, elders ensure that indigenous practices and knowledges are continued and sustained from generation to generation. Moreover, a qualitative study conducted in Limpopo with nine Pedi psychologists argued that in the province it is common for communities to seek out help with decision-making regarding central issues related to community development, land use, health issues and environmental issues from respected elders in the community (Sehoana, 2015). This was echoed by a qualitative study conducted by Obioha and T'soeunyane (2012) in five villages of Lesotho with older people. The study observed that elders play important roles towards stability and growth of the Sotho society and their families (Obioha & T'soeunyane, 2012). The study further acknowledged that even though elders might be perceived as weak and physically frail, their role in the society continues to be valued. Furthermore, is has been argued that each elder in the community possesses distinct knowledge that is invaluable, in basic terms they are "experts on life" (Joseph, 2014).

The experiences of the elders and what they learn from their own experiences as well as how they interpret those experiences are important parts of being an elder, it is through this that they are able to communicate their experiences and what they have learnt to others (Viscoligliosi et al., 2019; Mohammed, 2018). Age is not necessarily a significant and only factor of this process and being an elder, however experiences throughout the various stages of life enables a person to reflect thoroughly on their past lived experiences. Some elders are able to completely reflect on their experiences compared to others because each elder has unique experiences, learning, knowledge as well as personality (Wilson et al., 2010). Regardless, they all have something unique to offer in the society, some might be specialists in healing practices of illness such as mental illness, some might be experts in other teachings and ceremonies while others may have other expertise (Michel et al., 2019; Schure et al., 2013).

Historically elders have been valued for their experiences, knowledges, and insights that they share with others. From an early age, children are taught to respect elders without question. This is a significant value in collectivist communities. For example, Beiroth (2017) conducted a qualitative study in Lesotho with old and younger Basotho and found that there are titles used to address elders (Beiroth, 2017). These are used to signify respect to those who are older in the community. The study explored how roles of elders and younger people are different in the

communities of Lesotho. However, it has been argued that in industrial societies elders' value is often not recognized (Bassset, 2009). They are denied responsibilities and considered out of touch. The younger generation perceives them as conservative, petulant and pessimistic (Hernandez & Gonzalez, 2008). However, a qualitative study conducted in Lesotho found that elders as opposed to the youth are regarded as carriers of traditions that they pass on generation to generation (Beiroth, 2017). Furthermore, as much as elders are willing to share their stories and past experiences, a quantitative study conducted in eastern Canada with older people found that how elders reminisce about their lives depends firstly on the relationship they share with the listener and secondly on who is listening (Randal1 et al., 2015). It was found that different listeners elicit different stories from the elders.

2.5.4 Culture, personhood, and well-being

Worldwide, there are diverse cultures and one of the distinct features of cultures is the meanings they attribute to being a person (Adjei, 2019). Foundational concepts such as sense of self, agency, and morality form part of Western psychology. Western culture believes that the self is responsible for explanation of behaviour (Saft, 2014; Markus & Kitayama, 1998). Thus, Western psychological thought seems to understand personhood as a personal experience that involves an autonomous, single being living in isolation from the cultural systems and others of the community in which the person is imbedded in. Personhood in Western thought and society is deeply rooted in the culture and ontology of individualism (Nwoye, 2017; Markus et al., 1996). However, the notion that a person is value free and a self-contained agent who controls his/her fate is foreign in African thought and societies. In African thought, persons cannot be separated from others, nor can they live in isolation. Africans understand themselves through the humanity that is embedded in their cultural worlds. They experience the world through the work or worlds of others (Bradbury & Miller, 2010). African psychological thought asserts that the African worldview is normative, communal, and guided by meaning systems and specific values that inform the Afrocentric paradigm of human functioning and knowledge (Adjei, 2017; Nwoye, 2015; Ikuenobe, 2006; Mbiti, 1990).

In African societies, the community values and beliefs are based on how things are rather than how things are ought to be (Neequaye, 2020; Adams, 2005). The following common African statements: "I am because we are, and since we are, therefore I am" and "I am because we are" reflect on the common concept of "Ubuntu" (Mbiti, 1990, p. 141), which sums up the person-community relationship in African societies. Ubuntu is the humanity towards others and caring

for other people's wellbeing (Baloyi, 2008; Mangcu, 2008). For example, in most rural Zulu communities, Ubuntu is expressed through maintaining a balance between animals, plants, humans, earth, sky and ancestors (Ramose, 2014). Consequently, by doing this they ensure that there is a balance and coexistence between harmony and chaos as well as order and disorder (Ramose, 2014; Ngubane, 1977). Furthermore, people must continuously and consistently work together ("nokubumbana komphakathi") to renew social coherence and harmony to prevent chaos and disorder.

Sense of personhood in African societies provides foundation for African wellbeing, rationality, and knowledge (Neequaye, 2020; Adams & Dzokoto, 2003). However, psychological science and practice are implicated by the African conception of personhood. For instance, psychological concepts such as suicidal ideations, interpersonal aggression, mental health, enemyship and friendship have been found to be linked with communal perceptions of the self in Africa, supported by empirical evidence (Adjei, 2017; Osafo, 2012; Adams, 2005). Thus, personhood in African worldview influences mental health and well-being (Osafo, 2012). That is, people maintain unity and harmony with an ultimate being and connectedness glues the self, others and nature ensuring a cosmological balance. In African worldview, as long as this balance is maintained, there is mental health and wellness (Andoh-Arthur, 2015; Ramose, 2014). Moreover, understanding people within a given cultural context and how their society or context socially enables them to certain behaviours expands our understandings around the behavioural patterns of perpetrators and victims of violence such as gender-based violence in various cultural systems.

Furthermore, Adams (2005) state that the relationality of personhood in African contexts perpetuates what is called objective self-awareness which is defined as person's feelings of constantly being socially evaluated by the society which may consequently compromise their mental health. The objective self-awareness has been associated with enemyship in Africa. Furthermore, Adams (2005) analysed three studies from Ghana and the United States on "enemyship" and stated that the concept can simply be defined as one wishing ill for others because of malice and hatred. Enemyship is considered to be common in Africa and pathologized, however others have argued that it is also common in Western societies and reflects elements of interdependence and personhood (Adams, 2005; Adams & Plaut, 2003; Parin et al., 1980). Others believe that enemyship is a superstition (Adams et al., 2012; Jahoda, 1970). However, rather than a superstition, the African belief in a person as an object is manifested in the experience of enemyship. This might be interesting and relevant for

understanding mental health and illness. While there are lots of positive elements of ubuntu or sense of personhood in African thought such as an interest and commitment to the welfare of others (Adams et al., 2012). To understand psychological distress, a focus on the suspicious elements of the phenomenon needs to be explored. Even though, Western psychological thought encompasses various existing theories of personhood or human personality, some of which speak to our experience, an African version of personhood is still necessary (Nwoye, 2015).

2.6 Causes of mental illness

2.6.1 Witchcraft

The term witchcraft has been used to describe wide range of activities that are of evil nature and used interchangeably with terms such as magic, occult and enchantment. Some scholars like Mbiti argue that if we are to ask if witchcraft should vanish, we should also ask when Western faith will die (Moore & Sanders, 2001). Witchcraft has long been recognised as uncivilised. During apartheid, any practice and belief in witchcraft was perceived as uncivilized, baseless, and repugnant (Niehaus, 2012; Moore & Sanders, 2001). People believing in witchcraft were seen as uncivilized and primitive and enlightenment discourses believed that witchcraft beliefs and practices would ultimately disappear with the advent of education, Christianity, and Westernisation (Kroesbergen-Kamps, 2020; Moore & Sanders, 2001). Nguni, Shona, and Sepedi terms “umthakathi”, “muroyi “and “moloi” denote witches as those who are troublemakers, eat corpses, dance naked and cause misfortune. Some claims that witches can fly may be mythical however other activities may be factual (Douglas, 2013; Moore & Sanders, 2001). Mbiti (1990) argues that we should abandon the colonial assumption that witchcraft is a myth existing only in the mind of the uncivilized and ignorant. He contends that it is a fundamental marker of African identity because witchcraft is a traditional cultural concept that continues to dominate the beliefs of African people (Mokgobi, 2012). A quantitative South African study conducted by Mokgobi (2012) argued that people may attribute the cause of their illnesses to witchcraft and dismissing the fact that there are alternate ways of looking at health issues is a major barrier to integrating Western and traditional systems of health. It is assumed that around the world, witchcraft beliefs and practices have diminished with the rise of Westernisation. However, in Sub-Saharan Africa, most people still believe in witchcraft and its practices (Douglas, 2013; Miguel, 2005; Moore & Sanders, 2001). It is argued that there are two kinds of witchcraft. The first kind of witchcraft is one in which the

witch functions at night and has inherited the trait from someone who was also a witch. The second kind of witchcraft involves the use of medicine or "muthi" to cause others illness and misfortune. However, it seems like there is not much difference between the two as they both ought to bring misfortune and illness in other people's lives (Douglas, 2013; Hammond-Tooke, 1989). Witchcraft is driven by various factors, one of them being jealousy by those close to the targeted person because of what he or she has acquired or has potential to achieve.

In African contexts, social experiences such as death, sickness and illnesses are most often believed to be due to witchcraft (Yaseen, 2013). Thus, we can understand witchcraft as an explanatory model and theory of misfortune for most psychological, economic, social, and health-related problems and experiences in contexts where the belief in witchcraft exists (Levack, 1995). For instance, a study conducted in the Vhembe district of Limpopo province explored the understandings of mental illness among VhaVenda traditional healers and found that sorcery, witchcraft, heredity, disregard of spirit possessions and cultural norms were regarded as the main cause of mental illness and misfortune by the participants (Mufamadi & Sodi, 2010). Other mixed methods and quantitative studies conducted in rural villages of South Africa and Nigeria have found similar results (Zondo, 2008; Gureje et al., 2005).

Most people have an idea or picture of how a witch looks like, it is said that a witch is usually an older woman who is isolated from the community and has odd living habits. For example, a qualitative study conducted in Ghana found that the development of mental illness in women was understood and believed to be due to the practice of witchcraft (Ofori-Atta et al., 2010). The study aimed to explore how 120 participants understood the causes of mental illnesses in women. Women who were believed to be mentally ill were accused of practicing witchcraft and inflicting pain on others in their communities. The society's identification of a witch might be an unconscious or conscious way of labelling someone who has mental illness or odd behaviour especially in cases where the severity of the behaviour is insufficient for a diagnosis of a psychiatric illness (Richman & Hatzenbuehler, 2014; Ssebunnya et al., 2009; Moore and Sanders, 2001). This varies from place to place and depends on how tolerant the society is. The way people express themselves when mentally ill through language is highly influenced by their cultural background (Chikaodiri, 2009; Neki et al., 1986). However, people's behaviour is judged in relation to acceptable norms in each society.

Furthermore, there are studies that have been done in psychology which have looked at witchcraft and psychopathology (Chaudhry & Rafi, 2012; Dein, 2003; Eldam, 2001; Ivey &

Myers, 2009). These have focused on how witchcraft influences the way that psychological distress is expressed. Furthermore, it is said that what would be indicative of psychological distress is often taken as an indication of presence of spirit possession or witchcraft within the afflicted person (Chaudhry & Rafi, 2012; Lombo, 2010; Ivey & Myers, 2009; Mashamba, 2007; Eldam, 2001). The same findings were found in studies conducted in Nigeria, South Africa, and Gambia (Schierenbeck et al., 2013; Gureje et al.,2005; Coleman et al., 2002; Ohaeri, 2001). Here, study participants put forward similar causes of mental illness. Heinemann (2000) applied depth psychology in an attempt to understand the reasons underlying witchcraft accusations. He found that jealousy and "enemyship" are one of the main reasons behind these accusations. According to Kimotho (2018), most African people, irrespective of socioeconomic and educational status, believe that supernatural forces such as witchcraft play a role not only in causation of mental illness but also in other medical illnesses. Thus, this seems to be one of the reasons why non-Western others and cultures usually do not conform to biomedical or Western psychological theories of mental illness (Kimotho, 2018).

2.6.2 Disregard of cultural norms

Ancestors and traditional values, customs and norms are held in high regard in African societies (Mkhize, 2004). This has been emphasised by a qualitative study conducted in Limpopo with vhaVenda traditional healers (Mufamadi & Sodi, 2010). It is believed that when a person passes on, he or she becomes an ancestor and connects with other ancestral spirits. The person will keep in contact with the family and protect them from any misfortune or ill-health (Mufamadi & Sodi, 2010). This is perceived as a balance between the living and non-living world which is important for health (Uys & Middleton, 2010; Manyike & Evans, 1998). However, should it happen that the ancestors are disregarded in any way, illness may occur among one of the family members as an attempt to alert them that their ways should be changed. This does not necessarily have to be mental illness because it can also be physical illness (Uys & Middleton, 2010). An old qualitative study by Nzewi (1989) captured the significance of social harmony and moral or good behaviour in the aetiology of general health in Nigeria. The study found that Nigerians believed that dysfunctional behaviour and disobedience are punishable through ill-health and misfortune. Moreover, a South African study by Juma (2011) found that the participants expressed that worries and guilt of disregarding ancestors and cultural norms can make the person ill. For example, a man who has sexual relations with his brother's wife may experience high levels of stress whether anyone knows about it or not, as it is considered to disturb his social harmony (Sogolo, 1993). Exceptions may be in circumstances

where the brother is infertile, and his male sibling would have to step in his place to impregnate his wife with the knowledge of the elders. Even though this is considered to be an old practice today and frowned upon, some African cultures still practice it to maintain harmony and well-being among families (Mashamaite, 2015).

2.6.3 Ancestral spirits and spirit possession

From an African standpoint, mental illness can be due to being possessed with a form of spirit such as an ancestral or "thwasa" spirit. A qualitative study by van der Zeijst et al. (2020) conducted in a rural area of Kwazulu-Natal with 20 traditional healers found that most mental disturbances or psychological distress are understood to be due to ancestral spirits. Thus, this suggests that one might have to seek out spiritual and traditional help to restore their health. In the case of an ancestral spirit, when a relative who has a calling to be a traditional healer ("bongaka" in Sepedi) dies, they pass on the gift to one of the family members. A qualitative study conducted in Limpopo illustrated that the onset of psychological distress or mental illness can be interpreted as an invitation to be a traditional or indigenous healer (Mufamadi & Sodi, 2010). The chosen one may start having dreams at night, lose their appetite, become thin and might be diagnosed with some form of "anorexia nervosa" according to Western Psychiatry (Van Duijl et al., 2014; Hadebe, 1986). The person may hallucinate and display other symptoms which are similar to schizophrenic disorder. For instance, a qualitative study conducted by Lombo (2010) in Eastern Cape, Queenstown on "mental healthcare practitioners' perspectives of mental illness" who are part of the isiXhosa ethnic group found that participants largely believed that mental illness results from failure to comply with cultural practices, refusing to accept the calling and witchcraft. It is not common that the person who is destined to be a traditional healer accepts the calling immediately, some hesitate at first because of their religion, own personal values and agenda and might not want to be a healer or even believe in ancestors (Mufamadi & Sodi, 2010). However, failure to perform the ritual or accept the calling may result in prolonged physical illness, mental illness or even death.

Moreover, a person may be possessed by the spirit of someone who has died and not put to rest peacefully or properly in the spiritual realm. This kind of spirit is usually referred as "Indiki" in isiZulu. In this instance, the possessed person may need to carry out rituals with their family with the help of a traditional healer to restore their health (Verginer & Juen, 2019; Ngubane, 1977).

2.6.4 Amafufunyana or "Madness"

Amafufunyana is described as a severe form of depression with depressive and psychotic symptoms including suicidal tendencies, isolation, sadness, and hysteria (Mzimkulu, 2000; Ngubane 1980). This is a cultural bound syndrome which is explained as a form of spirit possession (Sorsdahl et al., 2010). In most African societies, when one is displaying severe symptoms of mental illness, they would be described as being mad or having this condition "amafufunyana". Amafufunyana or madness results from sorcery in most instances and is well recognized as the label given to someone who is mentally ill (Ngubane,1977). For instance, a hermeneutic phenomenological study conducted in Eastern Cape with traditional healers found that amafufuyana is believed to be caused by supernatural forces which are not seen by the physical eye (Gqibitole, 2017). Amafufunyana is caused by a mixture of ants and soil taken from a cemetery and put on the path of the person targeted. The person may then start throwing themselves on the floor and taking their clothes off (Yew-Siong, 2021). This might even elevate to committing suicide and engaging in violent acts (Mzimkulu, 2000). However, the act of sorcery with an intention to make a person mad is not always successful. In some instances, the person might have a powerful presence that weakens any evil spirits and acts or be protected by powerful ancestors (Mdleleni, 1990).

2.6.5 Stress

Stress is an important aspect to consider when talking about causal factors of mental illness. Stress is not isolated from day-to-day life events that people experience that can compromise one's mental health (Khan & Khan, 2017). Stress is defined as an experience that involves difficult emotions accompanied by behavioural, cognitive, biochemical, and physiological changes due to specific stressor (s). An old study by Wolff (1968) argued that stress is an inevitable aspect of life. People are bound to come across stressful experiences and events in their daily lives. However, he emphasized that people may experience different stressors which carry diverse meanings for different people in society. Stressors can be external (e.g., change, loss, tragedy) or internal (attitudes, thoughts, beliefs) (Kaur & Bashir, 2016). If prolonged or continued, stress can put a person's mental and physical health under strain as the individual attempts to manage the environmental demands. This might consequently lead to biological and psychological changes that can in turn be accounted as an illness, either mental or physical (Salleh, 2008). Qualitative studies conducted in Western contexts have argued that stress plays a significant role in the development of common mental illnesses in the society such as

depression, anxiety etc (Khan & Khan, 2017; Baum & Posluszny, 1999). Moreover, it has been argued that in Korea, stress has led to depression which might compel the affected person to commit suicide (Lee & Ham, 2013).

2.6.6. Nutrition

The food that we consume daily do not only play a significant role in ensuring that we are physically healthy, but on our mental health as well. However, scholars have argued that there seems to be lack of awareness in society regarding the relationship between mental illnesses and nutrition as compared to how nutritional deficiencies are related to some physical illnesses (Jacka et al., 2017). For example, mental illness such as depression is usually understood as strictly emotionally rooted or biochemical- based. However, Jacka et al. (2017) conducted a quantitative study in Australia to explore the association between depression and dietary patterns and argued that there is a limited perspective of how depression develops because nutrition plays a significant role in the onset, duration, and severity of the disorder. In contrast, Moser (2012) has argued that the majority of people already know that eating foods such as fast food, sugar, fat etc that are unhealthy and low in nutrients has the possibility of impacting a person's level of energy, body weight and their mood as compared to consuming a diet high in vegetables, nuts, and fruits. Moreover, a quantitative study conducted by Ruusunen (2013) with middle aged fishermen man from eastern Finland, explored various kind of dietary patterns and found that diets rich in vegetables, whole grains, berries, fruits, and fish had a positive impact on reducing the risk for developing mental illnesses. The study also showed that adherence to a Western cultured died increased one's risk in developing mental illnesses. Similar results were found in a study conducted by Roca et al. (2016) in four European countries. This study utilized findings obtained from a MooDFOOD prevention trial which aimed to explore how dietary patterns can prevent onset of depressive symptoms in overweight individuals. Hence, it was discovered that the impact of nutrition on the prevalence of mental illnesses and health needs to be further explored. There has been an increase in literature that explores the relationship between mental health and dietary patterns. Longitudinal and cross-sectional studies in Western countries have shown that when one consumes a highly processed or Western diet, they are more likely to develop mental illness, such as anxiety and depression (Jacka et al., 2017; Owen & Corle, 2017; Jacka et al., 2012). Nutritional psychiatry and neuroscience as a recent discipline can shed light on how nutritional factors are intwined with emotions, behaviour, and human cognition (Rao et al., 2008).

2.6.7 Substance abuse

There is a standstill debate in literature about the relationship between substance abuse and mental illnesses. It is questioned if mental illnesses predispose people to substance use and abuse or vice versa (Claro et al., 2015). Substance abuse refers to the maladaptive use of substances such as but not limited to alcohol, nicotine, over-the counter and prescribed drugs, inhalants, solvents, indigenous plants that can potentially cause significant distress or impairment mentally and physically (Routledge, 2007). Historically, available data shows that people have persistently opted to use substances that alters their mental and emotional states (Sewell, 2015). For example, a quantitative study conducted in Malawi about attitudes towards mental illness found that the majority of the participants acknowledged that most of the mental disorders in their context is due to abuse of drugs and alcohol (Crabb et al., 2012). This suggests that substances such as alcohol and a variety of drugs have been observed to be one of the common causal factors of mental illness. However, it has been questionable how substance use can simultaneously be detrimental to one's mental health and be used legitimately for medical reasons. Nonetheless, substance abuse is argued to not only alter and shape personal development but can also impact the myriad biopsychosocial factors that build a person holistically (Crabb et al., 2012; Newcomb & Locke, 2005). In fact, substance abuse has been intertwined with a myriad of social/family, psychiatric, medical, physical, legal problems globally (Sewell, 2015). The prevalence of substance usage is greatly influenced by the cultural norms which are constantly changing in society. Substance abuse is argued to be more prevalent in adolescence and young adulthood but can continue into late adulthood (Sewell, 2015). One of the risky behaviours considered to be a significant concern among young people in the South African context is substance abuse, which puts the youth at a high risk of developing psychiatric disorders (Routledge, 2007). For example, a recent study conducted by Okoro (2018) in the United States aimed to explore the relationship between the development of mental disorders and substance abuse, it found that adolescents who abused alcohol and marijuana were more likely to develop mental illness. Additionally, a quantitative study conducted by Pencer and Addington (2003) with 266 psychotic patients reported that the use of substances was found to be associated with development of psychotic symptoms.

2.7 Healing systems for mental illness

2.7.1 Traditional and Western modes of healing for mental illness

Culture not only shapes how mental illness is perceived and expressed but also the pathways one chooses to follow for healing (Matsumoto & Juang, 2016; Komiti et al., 2006). People seek out help for mental illness and other illnesses from traditional, biomedicine and religious mediums of healing. These healing systems are important because they play a role in healing and sometimes in diagnosis of mental illness (Pretorius et al., 2009). A qualitative study conducted in Namibia by Bartholomew (2016) argued that there has been an ongoing debate about traditional and Western pathways of healing for psychological distress in various cultural contexts globally. According to Dlamini (2006), there are currently three existing healing care systems in South Africa, namely, the traditional healing system, Western system, and a holistic or integrative approach to health care. However, few studies have been conducted regarding the integration between these healing systems. Traditional healing practices are those that are not biomedical or strictly religious. The practice is traditional or indigenous because a practitioner evokes African understandings of cosmology to heal others and improve their well-being. Historically, there were many types of traditional healers who performed various functions for African communities; these included detecting criminals and witches, negotiating with ancestors, "doctoring" armies, bringing rain, and using surgical procedures and herbs to heal variety of illnesses (Truter, 2007). However, traditional healers are differentiated as diviners and herbalists. In South African cultures, the definer is refereed as "ngaka" (Pedi), "mangome" (Tsonga and Venda). The diviner is guided by ancestors and trained by another diviner who is experienced (Truter, 2007). Ancestors provide the trained diviner with powers to diagnose and heal people. While on the other hand, an herbalist known as "inyanga" in Zulu uses medicines gotten from various substances like roots and plants to treat the presenting illness of their clients. In most villages especially rural areas, there is at least one traditional healer who carries the burden of the community's mental illness (Abbo, 2011). Additionally, studies conducted in Ghana by Kpobi and Swartz (2019), and South Africa by Gibson (2014) found that prayer is believed to heal various illnesses such as mental illness by those who are religious.

Barriers that are considered to be fundamental when someone makes a choice about which healing system, they will seek help from, are: stigma, cultural and religious beliefs, socioeconomic status, affordability, accessibility, education status etc. According to Miranda

and Patel (2005), local concepts that are important when talking about mental illness are treatment acceptability and stigma which usually influences whether people seek help or not and attributes of causation such as witchcraft. Many people particularly in South Africa seek help from traditional healers as compared to Western practitioners. It is estimated that in South Africa, about 8 out of every 10 people seek healing from traditional and religious healers at the same time or before consulting with Western mental health professionals (Ross, 2008; Mkhize et al., 2004; Cooks, 2002). According to Truter (2007) and Patel (2011), in Sub-Saharan Africa, the ratio of indigenous healers to patients is estimated to be about 1:500. This suggests that indigenous modes of healing are predominately used in the African context.

Thus, indigenous healers are usually the first to be contacted for mental illness because they are easily accessible and available to the community and are more informed of the existing cultural belief system in that particular community (Pham et al., 2021; Ndetei et al., 2008). For example, a quantitative study conducted in a rural village in Nigeria found that Western mental health services are not usually initially consulted among the general population (Nonye & Oseloka, 2009). Similarly, a qualitative exploratory study conducted from five regions in Ghana with 120 participants about the use of faith and traditional healers found that the prevalence of traditional modes of healing is high because traditional healers understand aetiology of mental illness through the lenses of cultural explanatory models (Ae-Ngibise et al., 2010). It has been argued that among other reasons of why they are prevalent is because they are easily accessible and available, affordable as well as provide psychosocial support (Mbwayo et al., 2013; Ae-Ngibise et al., 2010). A qualitative study conducted by Mufamadi (2001) in Venda among traditional healers articulates this very well. Participants felt that traditional healers are better positioned to understand any illness of their clients as they have great understanding and knowledge of their clients and because they share similar beliefs and customs. Traditional healing is also prevalent in other societies. For example, Native Americans, Chinese, Australian Aborigines depend on indigenous medicine to treat psychiatric, spiritual, and physiological conditions (Mokgobi, 2012). However, it must be noted that traditional healing or modes of healing in particular societies and cultures are not necessarily universal nor homogenous, rather they will vary from region to region, culture to culture and from religion to religion (Moletsane, 2005).

Furthermore, a study conducted in South India by John (2014) and another by Madu et al. (1996) in Limpopo on traditional rituals and healing, identified three steps of traditional healing. Firstly, the client visits the healer, in most cases without an appointment however the

healer is aware due to the connection with the spiritual world. Then, “ditaola” or bones are thrown and used as diagnostic tool. Once that is done, the client is diagnosed and the form of treatment available and appropriate for them is communicated. The third phase is the treatment phase in the form of herbs, rituals, oily substances etc. Hence, Meissner (2003) argues that traditional healing will never diminish as it has long existed in South Africa prior colonization by the Dutch and continues to exist in the present.

However, the reality is that narratives of traditional healings go unpublished, while the Western modes of healing for mental illness are extensively studied and considered as the standard and universal tool for treating psychological distress. Treatment in Western healing systems is administered through various medications such as mood stabilizers, stimulant medications, anti-psychotic, and anti-anxiety drugs (World Health Organisation et al., 2005). Mental health services rooted predominantly in a Western perspective are offered by a multidisciplinary team including psychiatrists, psychologists, social workers in South Africa. Moreover, it is estimated that in South Africa there are about 22 psychiatric hospitals with 36 psychiatric wards (Tromp et al., 2014). Mental health services are delivered at primary, secondary and tertiary health care levels in the country. Primary health care works with people who show severe mental illness such as psychosis and schizophrenia to manage the symptoms by providing follow-up medication. Secondary health care deals with psychotropic medication which is often available in general hospitals for outpatient facilities and inpatient psychiatric wards. If it happens that those who are affected cannot get sufficient care in the community, they are referred to tertiary health care (Marais & Petersen, 2015; Petersen et al., 2009). Overall, the Western approach to treating or healing mental illness is rooted on the principles of technology, science, and clinical analysis. In most cases, illnesses are understood through biological lenses utilizing the ICD-l0 and DSM-5 as tools for treating and diagnosing mental illness (Kriegler, 2015; Watters, 2010).

Even though most people consult with traditional healers on the African continent especially in South Africa, mental health practitioners are currently being trained using Western models such as ICD-10 and DSM-5 because they are supported by rational and scientific knowledge (Musyimi et al., 2017). While traditional healing is critiqued to be based on magical, mystical beliefs and unproven in efficacy. Western modes of healing despite being mostly used in the South African healthcare system are criticised of oppressing people, of being conservative and forcing them against their will to conform to social roles they may not wish to take on (Musyimi et al., 2017). It appears that traditional and Western modes of healing are not immune to flaws in one way or the other. Hence, the choice of which healing system to seek from is influenced

by a wide range of factors that include availability and affordability of services, knowledge of resources and local social dynamics. For example, qualitative studies conducted in rural areas of Kenya and India have found that among participants, mental illnesses that are believed to be caused by supernatural forces such as witchcraft are considered incurable by biomedicine and can only be cured by traditional modes of healing (Mbwayo et al., 2013; Saravanan et al., 2008). Thus, misdiagnoses might occur if mental health professionals lack understanding of factors that inform the meanings of mental illness held by communities (Patel et al., 2013; Eaton et al., 2011). Therefore, this study argues that in acknowledging indigenous knowledge systems, an integration of traditional and biomedical healing systems has a potential to provide a complementary system that prioritizes plural health care. This might provide patients a comprehensive and holistic healthcare system (Sorsdahl et al., 2010).

2.8 Conclusion

In drawing from what was discussed in this chapter, the first section touched on the history of mental illnesses or disorders where they shifted from being described as madness to being classified in the late 19 centuries by the Greeks, which consequently influenced the development of what is considered as diagnostic instruments (ICD-10 and DSM-5) for mental disorders in the 21st century. However, it has been pointed out that even though there has been effort made to ensure that there is a shift in where mental illness was when they were first classified, they continue to be marginalised as compared to physical health. Moreover, the literature review looked at how mental illness is defined and conceptualised in diverse cultural contexts. it is evident that mental illness is conceptualised differently not only in Africa but globally. There are notions that mental illness or psychological distress is caused by physical and supernatural factors. Also, ubuntu/personhood and elders play an important role in maintaining health and harmony in collectivist societies. Ubuntu has been pointed out as a symbol for peace, harmony, and balance between the spiritual and physical world and this ensures that there is physical and mental health among the living if this is maintained sacredly. Moreover, elders are not only storytellers in the communities they are embedded in, but they play different roles as knowledge keepers, healers, teachers etc, which are important in passing knowledge about the causes and healing practices for mental and physical illnesses as well as maintaining health. Cultural beliefs and values play a significant role in the meanings, healing, and understandings of mental illness. Moreover, the literature showed that causes of mental illness are multifaceted and vary from one context to another. The literature suggests that mental health professionals need to be cognizant of diverse cultural contexts masked by

traditional knowledges that are context-specific, to be able to identify the needs of those who are mentally ill and respond appropriately within a particular cultural setting. Healing for mental illness in African societies is mostly sought from traditional healers. Traditional conceptualisations of mental illness in Africa are similar but not homogenous across regions and cultures. Thus, it is apparent that traditional ways of defining and understanding mental illnesses are culture-bound. This stems from how people make meaning of mental health and illnesses and where they seek help from. Hence, this warrants an intensive exploration of cultural beliefs across diverse context.

CHAPTER THREE

THEORETICAL FRAMEWORK

3.1 Introduction

Two theoretical perspectives are utilized to inform the current research. These are narrative and decolonial theories.

3.2 Narrative theory

The first perspective which the study is grounded in is narrative theory. It examines ideas, hopes, human experiences, and feelings by studying personal narratives (Gonzalez-Rico & Fuentes-Pineda, 2018; Riessman, 2008). Narrative is complex and this makes it difficult to define because of its interdisciplinary nature grounded in various fields of study such as anthropology, psychology, literary theory, cultural theory, and linguistics (Squire, 2005). Narrative can be used concurrently as a method of investigation/ analysis and as a theoretical orientation (Bruner, 1991). Therefore, in this study it will be utilized as a methodology and theory. Narrative theory asserts that people are narrative beings who create stories of their own lives to establish identity, sense of self as well as to understand mental health (Kugelmann, 2001). Life is a sequence of experiences and events, and we impose coherence and order to those stories and events by providing them with a story line to connect them together into a structural whole that has significance and meaning (Gonzalez-Rico & Fuentes-Pineda, 2018; Ricoeur, 1991). Thus, throughout life people unconsciously and consciously construct stories to organize chaos into a coherent narrative. Thus, Shlomith (2002) argues that "telling" empowers us to take control and create order which consequently enables us to contain chaos in our lives. Moreover, according to Kugelmann (2001), people develop and maintain a coherent identity by defining who they are, who they were, where they are and who they could be in the future. Thus, using a narrative approach could potentially unravel the complexity of issues of identity, self, and mental illness of people within the socio-cultural context they are situated in. According to Sarbin (1986), narratives are stories that guide and organize all human action across time while structuring events in a meaningful way that makes sense to the individual. Every person creates her or his own coherent story that is relatable to the present and past and imagines potential stories of the future (Somers, 1994). This means that the way people make moral decisions and understand the world is influenced mainly by the narrative structures surrounding them.

Additionally, Bruner (1990) argued that the way people adhere to specific cultural rules and avoid or claim particular identities is narrative. Through narratives, we find ways to interpret knowledges, interactions, and experiences in the social world. The advantage of studies that are guided by narrative theory is that they allow various levels of analysis to occur such as focussing on the context of the produced text, the structure of language and the setting in which the stories are produced. This allows us to trace human experiences that we want to know and understand (Andrews et al., 2013). For these reasons, this is an ideal theory for understanding meanings and understandings of mental illness among village elders.

As a methodology, narratives will be used to analyse the meaning and content of stories looking at the ways the stories are narrated and how they are told through personal accounts of the participants (Kugelmann, 2001). Through narratives, the study will explore stories that comprise various cultural domains including shared cultural meanings that influence meaning making of mental illness within their sociocultural contexts. This considers the fact that our identities emerge in line with specific historical, discursive, and social conditions (Sium & Ritskes, 2013). People resort to stories when asked to describe any disruptive or fascinating experiences they have had. This might be intriguing to scholars who may be interested in the power of narrative research to reveal the embodied experiences of social phenomena from the storyteller's perspective including the cultural and historical relationships that give context to these experiences. Narratives form part of a wider political process that provides communities, groups, and people the power and privilege to not tell or tell a particular story (Plummer, 1995)

Narratives include not only the experiences that have happened to the narrator but also captures the meaning that these experiences hold in the person's life story and context. In addition, narrative accounts for the ways the stories are shaped by the relationship between the person and the setting they are embedded in (Brough et al., 2013). In research, narrative structures the way in which participants and researchers comprehend and convey the meanings and experiences of particular events. Also, stories structure how people present themselves in ways that they would prefer to be perceived by others and how they account for their behaviours as well as those of others. Furthermore, through the use of narratives, people are able to explain how events have turned out, why they happened, who they were at that time, who they are now in relation to those events, as well as the reason they behaved in a certain way (Skultans, 2000).

In the context of research, the one who is a listener is the interviewer who often happens to be the researcher. Thus, the interviewer/listener and the narrator/participant co-construct the

narratives that are produced. This means that we must consider how the listener and narrator interaction can affect the story. For example, the narrator might narrate their stories in a particular way to avoid unfavourable attributions by the audience (listener). Nevertheless, every element of the story has a purpose or a reason for why it is there (Mishler, 1991). Narratives disclose a preferred version of the self that accords with the sociocultural context the person is enmeshed in rather than the essential self (Riessman, 2003). Hence, instead of focusing on the positional and interactional work of a narrative, researchers may be more attentive to the broader cultural and social systems of shared values and beliefs in which the narratives are rooted. Somers (1994) calls these shared cultural stories — 'public narratives' which families, states and institutions share to explain the events or experiences that happened in the past (Carretero & van Alphen, 2014).

3.3 Decolonial theory

The second theory that guides this study is decolonial theory. Among the theory's most influential proponents, are Maldonado-Torres (2007; 2011), Grosfougel (2007), Quijno (2007), Ndlovu-Gatsheni (2013) and Tamale (2020). The term decolonial is often used interchangeably with postcolonial thought due to their overlapping interest in the period following colonialism. However, decolonial theory asserts that post-coloniality has not yet come into existence because post-coloniality is rooted in Western civilization and its practices as well as its institutions which affect the people of the global South (Bhambra, 2014; Grosfoguel, 2011). Therefore, "proclaimed" post-colonial scholars should be considered decolonial theorists. Decolonial scholars, among other things, attend to how coloniality has affected the colonized and how the colonized show their resistance through engaging in decolonial projects, locally and internationally. Coloniality refers to patterns of colonial powers and structures that erupted and continue to exist in socio-cultural contexts in Africa due to colonialism, consequently defining culture, knowledge production, intersubjective relations, labour etc (Maldonado-Torres, 2007). The concept of coloniality could be understood in relation to colonialism, but they must be conceptualized as different. Colonialism is based on economic and political relations in which the prosperity of people or a country feeds on the power structures of another country. Hence, decolonial theory ought to challenge Eurocentric knowledge production by focusing on the epistemologies of those formerly colonized and recognizes how the dominant colonial structures in the society are continuously suppressing, excluding, or silencing indigenous narratives (Chakrabarty, 2009; Grosfoguel, 2008; Maldonado-Torres, 2007; Fanon, 2007; Mignolo, 2000).

Decolonial theory is increasingly being used to analyse social problems enabled by global North theories by integrating them with decolonial ideologies. This is often called the global South approach (Passada, 2019). The theory provides a platform for producing and thinking about knowledge, since it foregrounds thinking and knowledge production from Africa and other locations in the global South. In South Africa, decolonial theory helps us to understand how coloniality and colonialism have affected and distorted knowledge in Africa. Furthermore, the theory helps us to understand that even though people in African countries have overcome colonialism, they are still living as modern subjects of coloniality, and this affects how their stories are narrated as well as how they have difficulties narrating their own stories (Ndlovu-Gatsheni, 2013). Multiple forms of coloniality such as racial domination of colonialism continue to exist in the contemporary world. This is evident in how knowledge in the global North has always been regarded as the hegemonic standard and this has been imposed in the countries of Africa, consequently affecting knowledge production in these contexts (Maldonado-Torres, 2007).

Colonialism ensured that hegemonic Western cultural practices and traditions remain prevalent across Africa while subjugating, misrecognizing and pathologizing African culture using race to socially classify others (Cooper, 2013; Cooper & Nicholas, 2012). During colonialism, indigenous people's cultural world was colonized and Mkhize (2004) refers to this as "cultural colonization". Cultural colonization ensured that domains of culture such as language, intellect, aesthetics, and indigenous people are repressed and colonised, unfortunately it is argued that they remain colonised (Quijano, 2007). Africa is the prominent epistemic site that experienced both "theft of history" and colonial genocides (Goody, 2006), linguicides (killing of native languages) and epistemicides (killing of indigenous knowledges) (Wa Thiong'o, 2009). Therefore, the existing epistemic struggles we see in Africa today are both new and old. They are old in the sense that they began during colonialism and new because they are re-emerging at a time of intense global epistemic and systemic crisis (Ndlovu-Gatsheni, 2013). Thus, Africa is in need of epistemic freedom by decolonising knowledge from its current use as being singular into a plural form as "knowledges".

The historical background of knowledge cultivation and generation started with the traditional intellectuals/traditional elites comprising of kings, priests, magicians, merchants and praise poets of the pre-colonial Africa. These traditional elites led precolonial African societies and generated oral knowledge. However, the rise of colonialism was brutal to these African

knowledge keepers. Kings were captured, defeated, decapitated, and attacked. Their decapitated heads were transported to Europe to serve as ornaments in European Museums symbolizing the demise of the African continent/world (Ndlovu-Gatsheni, 2018). Enlightened by Cartesian Philosophy, African kings' heads were targeted by European colonialists due to the belief that they carried memory and knowledge. Most African women who were equipped with knowledge were regarded as witches and burnt alive during the 16th century (Grosfoguel, 2013). Furthermore, in the graveyard of African culture and indigenous knowledges, European colonialists sowed the seeds of European knowledge and memory starting with the church and school to execute the action (Weiner, 2018). They went on to impose colonial language as means to dissocialise African people out of their historical and cultural contexts into slaves of colonialism (Wa Thiong'o, 1992). Thus, colonialism achieved mental control over the colonized through use of culture, school, and church. The fruits of colonialism are evident today in the intellectual and scientific dependence as rooted in colonial education, linguisticides, epistemicides as well as the segregations it committed. To describe this, Wa Thiong'o (1992) states that "the language of my education was no longer the language of my culture" (p.11). Even though indigenous people have long been consumers of Western ideas, cultures and knowledge imposed on them, some African scholars critique and engage with Western epistemology from an African worldview (Weiner, 2018).

Thus, formerly colonised indigenous societies need to recraft a pre-colonial reality that claims back indigenous epistemologies and truths. Indigenous people need to regard themselves as carriers and sustainers of knowledge production without needing affirmation from colonial epistemologies (Sium & Ritskes, 2013). Hence, by acknowledging indigenous stories, we assert that indigenous practices, existence, and people still exist and reject the Eurocentric hegemonic standard of knowledge production. It is through this that indigenous people resist the colonial practices, knowledges and show that coloniality has not been successful in erasing indigenous knowledges, practices, and existence. Thus, by creating and telling their stories, indigenous people disrupt the colonizer's mythology about them (Tuck & Yang, 2012).

Decolonial theory is concerned with geo-politics of knowledge and geo-politics of knowing with regards to the who, how, when, and why is knowledge generated instead of produced (Mignolo, 2011)? By asking and dwelling on such questions, we can shift the attention from Africans being consumers of knowledge which is often referred to as "the colonization of being through the colonization of knowledge" (Mignolo, 2011, p. 39), to producers of knowledge.

Decolonization of knowledge is necessary to enable indigenous people to rewrite their own histories and change the focus of knowledge production to uplift and empower the present and future of the African continent and its people (Weiner, 2018). Through decolonization, research can be conducted in a manner that the worldview of those who have long being oppressed, exploited, and marginalized are provided a platform to speak from their frame of reference. It also involves questioning how disciplines such as psychology, sociology, education, anthropology, history etc have described and theorized the colonized other, while not affording the colonized other the space to speak for themselves (Chilisa, 2012).

Ndlovu-Gatsheni (2015) argues that we must return to the base in which we emphasize the use of indigenous languages that the local people speak. Linguistic additions such as translation are only necessary for deepening, widening, and strengthening the power of the languages spoken by the native people. This is specifically relevant to this study as the participants used their own language to tell their stories. The interviews were however translated into English thus pointing to the continuing hegemony of colonial languages. Most African people who have obtained formal education have isolated themselves from the indigenous ancestors and languages which Christian missionaries regarded as demonic and uncivilised. These imposed beliefs are still prevalent today. The reality is that the harm done by colonialism on indigenous people, cultures, knowledges, languages cannot be reversed. However, African people can begin to partake in a deliberate process of "learning to unlearn in order to re-learn" (Ndlovu-Gatsheni, p. 32). Thus, using decolonial theory, this research contends that African societies have a way of making meaning and constructing knowledge that is different from the Western or biomedical model which is worthy of being explored. This study explored older people as subjects of their own stories using their own languages (Creswell & Poth, 2018). Thus, this research is invested in enabling indigenous people and settlers to tell uncomfortable stories that have been silenced and not heard (Sium & Ritskes, 2013; Kaomea, 2003).

CHAPTER FOUR

METHODOLOGY

4.1 Introduction

This chapter provides an outline of the methods used in this research. It begins with a discussion of the nature of qualitative research in relation to this study. Moreover, participants, sampling and data collection procedure are described. This is followed by a section where the researcher reflects on her positionality or identity and investment in the study and how these might have influenced the research project. Moreover, how the data was analysed by the researcher is outlined. This chapter ends with a section on the ethical considerations of the study.

4.2 Research design

There have been ongoing debates about the merits of qualitative versus quantitative research in the social sciences (Rizo, 1991). However, what is of importance is that the appropriate methodology depends on the research questions and the phenomena that is being researched (Weiss, 1994). To understand the meanings of mental illness, a qualitative exploratory approach located within an interpretivist paradigm was adopted which enabled a focus on the understandings of mental illness for the participants. Moreover, the researcher aimed to apply decolonial and narrative theoretical framework, to explore meanings related to mental illness. The study was based on narrative research which involved collaboration between the participants and researcher, producing stories of their experiences about mental illness (Clandinin & Connelly, 2000). Qualitative research is sometimes critiqued for not being able to generalise because it uses small sample sizes in comparison to quantitative research (Greenstein, 2003). However, it must be noted that the aim of this research and qualitative study is not necessarily generalisation. Qualitative research provides an opportunity for scholars to be able to understand and interpret meanings people ascribe to values, actions, beliefs embedded within their social worlds. Hence, it provides an in-depth understanding about the participants' experiences, histories, perspectives, and social circumstance (Lewis & Ritchie, 2003), this is what the present study aims to achieve.

4.3 Research setting

The research was conducted within two villages of Greater Sekhukhune district in Limpopo province. The names of the villages are not disclosed to preserve the anonymity of participants.

The Greater Sekhukhune district is among the five districts in Limpopo province and has a population of approximately 1,125,000 (Ziervogel & Taylor, 2008). The map of Sekhukhune (*figure 3*) is provided below to show the surrounding areas. The district has 740 villages with some areas being urban, but above 50% of the population live in rural areas (Statistics South Africa, 2011). Ziervogel and Taylor (2008) stated that approximately 95% of the population in Greater Sekhukhune district reside in rural areas. The villages chosen for this study are in rural communities of Limpopo Province. Majority of the people who reside in this district are black, females and speak Sepedi as home language. The villages are impoverished; however, they have access to electricity, healthcare, and limited access to water and waste refusal services (Statistics South Africa, 2020). Interviews were conducted in the comfort of the participants' homes.

Figure 3: Map of Greater Sekhukhune district and surrounding areas

Source: (Maponya et al., 2014)

4.4 Sampling

The study used non-probability convenience and snowball sampling to select the participants. Snowball sampling is a technique in which research participants are requested to assist the researcher in identifying other potential participants (Emerson, 2015). On the other hand, convenience sampling is a method generally adopted by researchers where they collect research data from a "conveniently" available and appropriate pool of participants, in simple terms they make use of participants that are available and easy to access (Terre Blanche et al., 2006). These were ideal for this research because in some communities, the most convenient way to find its members is through requesting other members to refer people who meet the inclusion criteria of the study and available to participate (Welman et al., 2005). The sampling criteria included relevant characteristics for the research, willingness, and capacity to participate in the research and to answer the research questions. Moreover, the researcher is from a village in a rural community in Limpopo and this assisted in facilitating access to the community of potential participants. Through sampling, 10 participants were selected to participant in the research.

4.5 Research participants

The study recruited 10 people who are residents of two rural villages in Limpopo. Participants were African black women and men, aged 60 and older, and belonging to a Pedi culture. With regards to age, 65 seems ideal for this research because the World Health Organization recognizes people who are 65 years upwards as older people of the population, fit to retire and get old age pension and grants (World Health Organisation, 2010). However, it was decided before data collection began that should the researcher be unable to access all participants who are 65 years and older, the minimum age of participants may be dropped to 60. Only two participants were below the age of 65. The following *table 1* outlines the characteristics of each participant.

Biographical details of the participants

Table 1: Demographic profile of the participants

Pseudonym	Gender	Race	Age	Residential area	Community Role	Home Language

Ngwato	Male	Black	87	Limpopo- village 1	Pastor	Sepedi
Mahlako	Female	Black	66	Limpopo- village 1	MC	Sepedi
Ramolao	Male	Black	72	Limpopo-Village 1	Pastor	Sepedi
Hunadi	Female	Black	74	Limpopo-Village	Church advisor	Sepedi
Mamotse	Female	Black	70	Limpopo-village 1	Traditional healer	Sepedi
Tau	Male	Black	68	Limpopo-Village 2	Pastor	Sepedi
Kgalema	Male	Black	60	Limpopo-village 2	Youth Advisor	Sepedi
Mashego	Female	Black	80	Limpopo-village 2	Church volunteer	Sepedi
Lefokisi	Male	Black	70	Limpopo-village 2	Headman	Sepedi
Makwetla	Female	Black	64	Limpopo-village 2	Church advisor and children's healer	Sepedi

There were ten participants who resided in two villages of Limpopo within the Greater Sekhukhune district. There were five males (50 percent) and five females (50 percent). Eight of the ten participants interviewed were over the age of 65. The average age of participants was 71 years old. All participants spoke the Sepedi language. They all played significant roles as elders in their communities. Both the diversity and commonalities between the participants was beneficial for the research because it surfaced rich knowledge from different perspectives about mental illnesses.

4.6 Data collection and procedure

The first step was to get ethical clearance from the Wits Human Research Ethics Committee (Non-Medical). Initially the researcher planned to collect data during the June-July school holidays for two weeks however considering the outbreak of COVID-19 and that the participants of the research were human subjects; this was not possible. Therefore, the alternative was to collect data during August or September when travel restrictions were lifted. I then travelled to Limpopo to look for participants. I managed to get participants through

asking some community members about the elders who are available and would be willing to participate. Some of the participants referred me to elders with similar characteristics suitable for the research. When participants agreed to engage in the study, time and place of the interview were agreed on. Data was collected through audio taped, in-depth, individual, face-to-face semi-structured interviews by the researcher to prompt sharing of stories. The interviews took place at the participants' own homes where in some instances family members were present but kind enough to excuse themselves as to give the participant space to answer questions. All COVID-19 safety protocols were observed. These included physical distancing, regular sanitising and wearing of face masks throughout the interviews.

Interviews are a common data collection technique mostly used in qualitative research. Semi-structured interviews encourage participants to freely express themselves on a phenomenon and the researcher remains unobtrusive by creating space for follow-up questions (Greenstein, 2003). The interview schedule was structured based on the research questions of the study and past literature that explored mental illness (see Appendix D).

It is important to stress out that majority of older people in the Greater Sekhukhune district speak Sepedi and have little understanding of English. For this reason, interviews were conducted in Sepedi- one of the native languages in South Africa. Part of carrying out a decolonial and narrative project is to allow participants to express themselves in their own language. Before the interviews started, explanations of informed consent were given in addition to the information sheet, informed consent for audio and interview recording translated in Sepedi. Moreover, the interviews were conducted in Sepedi for a period of 45-60 minutes to allow older villagers to freely express themselves in their native language. Being able to speak Sepedi, a language that most people speak in the Greater Sekhukhune district enabled the researcher to conduct all the interviews. The transcripts were transcribed and translated by the researcher to English as the researcher is proficient in both English and Sepedi. Ten elders were interviewed in the Limpopo province in Sepedi, the language spoken by the interviewees. The researcher deemed this number sufficient because of the depth and richness of the data collected from the participants.

Moreover, before the interviews started, each participant was provided with an information sheet (see Appendix A), consent forms for recording and interviewing (see Appendix B and C). Unfortunately, most of the participants are not able to read which meant that a family member would have to read the documents for them. However, in some instances the researcher

read to the participants and verbally explained to them in the simplest way as possible. Participants then signed, and the recording and interviewing followed.

Furthermore, after the interviews, the researcher emphasized that should the participants have any questions about the research project, they should feel free to contact her via the details provided on the information sheet (see Appendix A).

4.7 Data analysis

Bogdan and Biklen (1998) state that qualitative data analysis involves breaking down unstructured and numerical data into meaningful components to convey what is significant by looking at patterns in the collected data. This process entails the researcher deciding what to tell readers as the data is often collected in surplus over a certain period of time. Webster and Mertova (2007) state that through narrative analysis, researchers are able to investigate, gather and analyse stories of events and experiences. The analysis is embedded in the stories we read, tell, and hear from a personal level and how these stories are embedded in our social interactions (Webster et al., 2007). Narrative analysis was used to examine the narratives in relation to the research questions. Narrative analysis does not have any set procedures however narrative researchers have written on the processes and guidelines that can be used to analyse narratives. There are four distinct methods of narrative analysis used by narrative researchers which are: structural, thematic, visual, and dialogic (Riessman, 2008). The approach of narrative analysis that was used in this study is narrative thematic analysis which focused on the content and themes of the stories (what is said). Narrative thematic analysis of the transcribed interviews was employed. This involved identifying themes that highlight relevant issues pertinent to the phenomena of study (Babbie & Mouton, 2005).

The study employed narrative thematic analysis as illustrated by Creswell (2014), guided by the following five stages:

Preparation and organization of the data: after the interviews were conducted, the audio-recordings were re-listened to and transcribed. During this process, the researcher organised the data by assigning pseudonyms. Names of the locations were removed to protect the identities of the participants. The researcher familiarised herself with the data through transcribing, re-reading the transcribed transcripts and re-listening to the audio recordings. This was beneficial for the analysis process because not only did the collected audio recorded data need to be transcribed, but it also needed to be translated which meant that the researcher

needed to familiarise herself with some words, phrases and sentences said in Sepedi and how they could be organized properly so that the narratives of the elders can be conveyed in English coherently. For translation, the researcher used the Northern-Sesotho dictionary which was accessed online to help with translating the transcripts as to convey the meaning ascribed to the stories by the participants in the best possible way to ensure that their narratives can be transferred to the broader South African community who might not otherwise understand written Sepedi language. Hence, the quotes that are presented in the findings chapter have been translated from Sepedi. All the audio recordings and signed consent forms are stored in a password protected device.

Gain general sense of the information; while transcribing, the emergence of any recurrent patterns or themes were noted down on the margins of the transcripts. To ensure that the meaning of the narratives is kept intact even in the translated transcripts, the researcher compared the transcripts in Sepedi with those in English to see if the codes, categories, and themes that emerged have similar meanings to evaluate if meanings articulated in these different languages significantly varied or not. In the process of trying to make sense of the data in Sepedi and English, the emerging codes and themes were evaluated to check if they answer the research questions or not.

Coding process: The data was coded manually. The codes identified important data in the transcripts. The researcher re-read the transcripts to see if new codes would be identified in order to extend on the existing ones or not. Similar codes assigned to certain quotes in the transcripts were grouped together to develop themes.

Categories or themes: Codes were then placed into a relevant category; categories that reflect the four themes (elders' roles in the community, older villagers' meaning making of people with mental illness, perceived causes of mental illness and healing practices for mental illness) and subthemes that have appeared representing the major findings of the study.

Interpretation of the data: Although interpretation occurs throughout the process from interviewing to formal analysis. In the last stage, in order to make meaning of the collected data and derived themes as well as codes, the researcher interpreted what the collected stories of the elders mean. This meant that the researcher had to constantly review and refine the codes, themes, and subthemes. After this was done, a draft was submitted to the research supervisor

to check if the data needs to be further analysed and if the existing themes might need to be refined in any manner.

4.8 Trustworthiness

Trustworthiness refers to the merit of the interpretations and methods utilized in the study (Connelly, 2016). To ensure the merit of the study's findings, four qualitative research principles namely, dependability, credibility, transferability, and confirmability outlined by Lincoln and Guba (1986) were utilized to safeguard trustworthiness.

Dependability is an important principle in qualitative research. Dependability ensures that the findings and data collected in research are reliable within a period of time and under certain circumstances (Hall & Roussel, 2014). This was ensured through consulting with the research supervisor during the data collection and analysis process to confirm if the themes are interpreted precisely based on the collected data from the interviews done with the participants.

Credibility in research speaks to the extent the derived findings are trustworthy and if they reflect the experiences and stories of the participants about a certain phenomenon (Corbin & Strauss, 2015). One of the ways to ensure credibility in research is through conducting member checks in which participants are given the opportunity to review transcripts and the draft report. However, member checks were complicated in this research because participants are unable to read. In this regard, the researcher could not predict the literacy rates of potential participants before collecting data. However, the researcher managed to listen to the recording with the participants and they were satisfied with their responses. Additionally, the interview schedule added on follow up questions which allowed for probing to get rich and in-depth data.

Transferability refers to the extent that the findings of a study can be transferable from one context to another, other than the one the research participants are embedded in (Hall & Roussel, 2014). To ensure the principle of transferability, the researcher ensured that a detailed description of the setting which is Limpopo is outlined for the readers in the first chapter. This allows readers to evaluate if the findings of the present study can be applicable to other settings other than Limpopo on a provincial scale or South Africa. Additionally, the researcher ensured that the transcripts were translated from Sepedi to English for report-writing so that the findings can be accessible to those who otherwise do not speak Sepedi. It is however important to note that since generalisability is not the aim of qualitative research, this study is transferable only to similar communities.

Furthermore, **confirmability** speaks to how the findings of the study precisely represent the data collected. This means that the findings must represent the experiences and perceptions of the research participants rather than those of the researcher (Polit & Beck, 2008). This was accounted for by providing an outline of how the data was analysed as well as verbatim quotations of the participants in the research report.

4.9 Researcher's self-reflexivity

Reflexivity addresses the researcher's subjectivity throughout the research process and therefore requires self-awareness of the researcher. Researchers need to be aware of how their self-location (across gender, race, class, sexuality, place of origin, language etc), interests and position influences or could potentially influence the stages of the research (Pillow, 2003). The rationale behind the topic is based on my earlier interest to understand issues surrounding mental illness, such as how Africans make meaning of mental illness which may be different to biomedical or Western conceptions of mental illness and health, and how this can aid in the implementation of effective mental health services. My interest is especially grounded on the fact that I grew up in a village where mental illness is defined differently, and this impacts how I view mental health services. I have a brother who is mentally ill and this has always been understood through cultural and religious lenses in my family and community. Thus, I was aware of my possible expectations and preconceptions about both the kind of data to be produced and participants. I used a journal to record my reflections throughout the research process. To avoid my own blind-spots such as overidentification with the topic, I focused on the stories of elders instead of those of younger people like me.

Taking into account that this research was conducted amid the COVID-19 global pandemic which has resulted in loss of jobs and showed visible inequalities between the privileged and those who are living under difficult circumstances with unemployment and poverty peaking in certain contexts, rural areas were not immune to poverty. There was an on-going debate between the poor and wealthy about who is greatly affected by the pandemic. I am constantly confronted by the realities of poverty when I visit my village and the neighbouring villages where the research was conducted. But this is not a shock to some of us who grew up there, it is our reality. Sometimes I forget that reality especially when I step into institutional and urban spaces as a student. I was ignorant to not reflect on how my positionality as a student who is enrolled at a prestigious university would mean for my research project when collecting data. Graham (2017) argues that our positionalities are engrained in intersecting identities based on

racial, class, gender, sexual orientation, educational, ethnic, and other identity positionalities. I was focused on the fact that I am an insider as I am from one of the villages in the Greater Sekhukhune district. I thought that would be enough. However, I was welcomed with suspicious eyes by some participants. I, however, suspect that what rescued me is my family name as it is well known in the Greater Sekhukhune district. One possible participant outright declined my request and said, "us people we just take, and we never give what we promise", it made me wonder about what I represented and was associated with in that moment. It then hit me, that because of my educational and my dual geographical status of being able to stay in a village and urban area, I represented privilege in my community.

Furthermore, when I passed the dilemma of how my positionality as a researcher and student was questioned. There came an issue of dressing style, I am a young adult who is aligned with the recent fashion trends. I wore my long comfortable trousers and shirts to the first participant's home. I remember one morning when my father was driving me to the village for the interview I had scheduled, he teased me about how I was dressed. He mentioned that I cannot wear trousers and not have my head covered when addressing the elders as it might be perceived as disrespectful to our culture and traditions. I received this as fatherly advice which allowed me to present myself in a more culturally congruent manner to the participants. I somehow knew this as a child and teenager, but it felt like it slipped my mind as a young adult who spends most her time in Johannesburg where I am not questioned because of what I wear. However, I realised that how I dress communicates different things in different contexts. I felt conflicted between being a part of the community but also an outsider. Lorde (1984) manages to provide clarity about this, by arguing that in some instances especially in community research and work one might find themselves as being both a sister and an outsider in a particular community.

4.10 Ethical considerations

Ethical approval was obtained from the University of the Witwatersrand ethics Committee (MACC/20/010) (see Appendix E). This process ensured that all the ethical dilemmas that may arise are well considered beforehand. The proposed study was not conducted with a vulnerable population and the subject of the study was not invasive and did not evoke heightened emotions or distress. The study was therefore not ethically risky.

Before the interviews are conducted, all the participants were told about the aim of this research project which was to explore and understand meanings, knowledges, and various healing systems of mental illness from the perspective of the narratives of older villagers. The participation information sheet attached as an appendix A provided participants a clear picture of what the study is about. Participants were informed that taking part in the study is voluntary. They were also told that they could withdraw from the study anytime they wanted. The researcher provided all the relevant information about the study including that the interviews would be recorded and take about 45-60 minutes. All aspects of this research were communicated to participants in a language that they understand.

Personal identifiable data was removed to ensure anonymity of participants. Total anonymity can however not be guaranteed because the participants are known to the researcher. However, the researcher reported the data in ways that do not reveal personal identification details. Participants' actual names are replaced with pseudonyms in this research report. Confidentiality was maintained by storing data safely and ensuring that no personal data cannot be traced to the participants. To ensure confidentiality, all notes and audio recordings during the data collection are kept in password protected device accessible only to the researcher. Only the researcher and supervisor have access to the data. The names of the villages where the interviews were done are not mentioned because stories are personal, and some stories narrated can be identified or traced if these villages are mentioned by name. Participants were given the participant consent forms for interviewing and recording separately and asked to read through them prior agreeing to take part in the interview to ensure anonymity and confidentiality.

CHAPTER FIVE

FINDINGS

5.1 Introduction

This chapter begins by presenting a narrative thematic analysis of the interview transcripts that explores the narrative themes that emerged. In this regard, the following themes are presented with their respective subthemes: elders' roles in the community, older villagers' meaning making of people with mental illness, perceived causes of mental illness and healing practices for mental illness. The analysis of the findings is supported by translated data from the participants. The chapter concludes by giving a summary of the findings of the study. The findings of the study are presented below.

5.2 Elders' roles in the community

The theme of elders' roles in the community speaks to the experiences and roles that they have accumulated within a period of time and intergenerational knowledges that they possess. This main theme with the underlying subtheme mentioned below explores one of the research questions that asks; "What do the narratives of older villagers in Limpopo reveal about their knowledges of mental illnesses? The stories about how their roles have changed and remained the same throughout time has allowed them to have various knowledges that enable them to understand mental health and illnesses in their communities. Their roles in their communities inform how they make meaning of and understand mental illnesses. Hence, it is important to stress that their knowledges and experiences about a variety of things such as illnesses are not isolated from the roles that they play in their communities. Through telling stories about their lives and what they have experienced, they communicate their intersecting identities to the listener.

5.2.1. Mental health, elders' roles, and experiences in village life

All ten participants contribute significantly to their communities in the respective roles they play. *Table 1* in the methods section provides a detailed outline of the various roles that all the participants play in their villages. Some of these include being cultural, spiritual, and religious leaders in the community and their families. Through their narratives, elders reveal their functions and value in the sociocultural and religious context they are embedded in. Their roles have exposed them to situations and experiences where they encounter those who are mentally

ill and this equips them with knowledge on how some illnesses including mental illnesses might present. In their pursuit to ensure that others are healthy in their communities, elders in the villages of Limpopo are exposed to people who have illnesses. However, some noted that it is challenging to fulfil the duties of their roles. Two elderly participants, namely Ramolao and Tau expressed how difficult their roles as religious healers are. They did not romanticize the roles they play and acknowledged how they come with unexpected dilemmas such as availing themselves beyond the context they are embedded in and beyond normal times of the day to provide healing when they come across those who are physically and mentally ill.

> *"I am a pastor…It is not easy, because you get woken up in the middle of the night while sleeping. Nobody likes to be woken up… People get sick anytime, so they would want me to pray over that person that is why they wake me up… according to the rules of church, as a pastor I should wake up anytime when I am needed." Ramolao*

Tau reiterated Ramolao's assertion and further expressed how he as a pastor does not only have a responsibility to serve his church but those who may need help from him outside his church. He observed that a person is chosen spiritually to fulfil such a significant role in the community. The role require great responsibility and commitment. However, it comes with its challenges because people in the community are not homogenous.

> *"I am a pastor in church but also for the community in general not only in church. Because when you are a pastor, you do not help those in church only but extend your help to the broader community… I cannot say it has been easy actually this it is a calling because it is difficult to be a pastor. Yes, it is hard to lead the community, it is difficult because people are not the same." Tau*

Expanding on the theme of responsibility, Lefokisi noted that his role as a headman was passed on to him by his father. "*The role that I am playing, I took it after my dad. I am in my dad's shoes now… my father was a headman of this village. I lead the community as my dad passed away in 2000…"* Tau and Lefokisi illustrate those elders that hold positions of influence and responsibility which are often passed on intergenerationally. In this regard, the past relates to the present. In the excerpt below, Kgalema highlights the importance of the youth adhering to their traditions for their well-being. He suggests that should one be led astray by Western traditions; they are at a risk of being exposed to illnesses and hardships of the world which

would consequently compromise their well-being and mental health. He reflected on his experiences as a young man where elders played a significant role in ensuring that knowledge about illnesses such as mental illnesses and how they can be healed using traditional practices is passed on to the youth.

> *"I provide guidance to the youth, young men and women. I always tell them that they must know where they come from. Most young people want to live Western lives forgetting their traditions and respect… We used to respect everyone who is an elder. Elders would teach us in groups about traditional herbs and their healing properties. They had so much wisdom…" Kgalema*

This coheres with Lefokisi's assertion about the significance of elders' roles as intergenerational, passed on from one generation to another. Elders can pass on knowledge about healing practices to the younger generation as shown in the excerpt above. Kgalema as an elder now, attests to how he has carried the knowledge from the elders of the past generation that he is passing onto the youth of this generation. It is apparent from the accounts of Kgalema and Lefokisi that narratives not only reveal how things are in the present, but also provide insight into the past. This is an illustration of how the narrator organises their experiences in a coherent manner.

Lefokisis, a headman and Mamotse, a traditional healer in one of the villages in Greater Sekhukhune district told stories that were similar to Tau and Ramolao's experiences of fulfilling roles of leadership in the community to secure the health of their villages. In particular, they contended that being an elder comes with a lot of responsibility and pressure on their mental health as it is stressful because people are diverse and there are always ongoing conflicts that predispose people to psychological distress. They find themselves questioned by those who seek help as well as by those who believe they are not doing enough as leaders of the community. Ubuntu, an attribute that fosters community and collective development, requires ongoing commitment to the well-being of the community regardless of the hardships that elders face. In the process of fulfilling their roles to the community, elders experience psychological distress.

> *"This role that I play my child is not easy at all… it is not easy because to lead a community is difficult. It is not simple because everything is your responsibility and you must take care of it… it can be funerals, it can be killings or other things happening in the village mhhm, they all fall on my back as a headman... Sometimes when you are*

herding cows, some are going to get into someone's farm and destroy it and eat their wheat… that will be my responsibility and I will be questioned that since this is one of my cows how can it just go into this farm and destroy it." Lefokisi

"I got initiated in traditional healing. This is my certificate for being a traditional healer… I work with healing children... The youth is stubborn, you would tell them that their baby is having some difficulties that you can help with. Instead of coming to you for help, they will go gossip about you. They will say you want money just to heal the child which is not the case. I understand that money is something that is hard to get and understand other people's financial situations mhhm so I would just heal the child first and the person can show gratitude afterwards." Mamotse

Mamotse and Lefokisi both suggest that holding significant roles in the community can be emotionally demanding. However, Ramolao who is a pastor observed that it brings some sense of joy to be in a position where one can heal other people. This suggests an alternative narrative of joy as compared to distress when one plays a significant role as an elder.

"You will pray for the person and their family will update you on how they are afterwards. They will tell you that the person got healed… Yes, it makes me happy because I would have managed to heal a child of God."Ramolao

The narrative accounts presented above show that elders embedded in diverse contexts play significant roles in their respective villages to ensure the wellbeing of their communities. These roles vary from being traditional healers, pastors/religious healers, and headmen. The narratives about their roles which include being healers and advisors for those who struggle with illnesses such as mental illness reveal that they have various knowledges about mental health. Their stories about their experiences show an ability to reflect on how this may impact them emotionally. Moreover, their work reveals a sense of ubuntu which fosters collective wellbeing in their communities. The narrative excerpts provided reveal that instead of the elders prioritising their own well-being and mental health in the context of the pressures of their roles and consequent psychological distress, they ensure that there is stability and health in their villages. They suggest that the harmony, health, and peace of the community is of great importance and is maintained through elders fulfilling their roles which are often passed on intergenerationally.

5.3 Older villagers' meaning making of mental illness

This theme explores how the elders of the two villages of Limpopo have come to make meaning of mental illnesses. This is inclusive of how they define mental illness and how they can identify someone who is mentally ill in their communities. This theme allows for an exploration of the two research questions namely: "How do older villagers in Limpopo make meaning of mental illness? and "What do the narratives of older villagers in Limpopo reveal about their knowledges of mental illnesses?" How they perceive and understand people who have come to be mentally ill reveals how they make sense of mental illnesses. Also, this shows the knowledge they have about mental illnesses through their narratives. How participants make meaning of mental illness influences how they define it and describe those who are mentally ill. They use the knowledge they have acquired to describe behaviours that are deemed to be concerning and can signal symptoms of mental illness in a person. Through their narratives, it is evident that there are existing indicators of mental illness in their communities. This signals when there is an imbalance in health and harmony. The role of elders is then to restore communal health and functioning.

5.3.1 Mental illness as "madness"

All ten of the participants associated madness with mental illness or someone who is mentally ill. Even though the concept of mental illness appeared to be understood well by the participants, they struggled to define the condition. Most of the participants understood mental illness through descriptive terms in which they said it is "madness". This seemed to be a common label that has been given to people who are mentally ill in the two villages. The narrative of mental illness as madness is understood through the narrating structures of mental health embedded in their context. Three participants namely, Ramolao, Hunadi and Mamotse explained how labelling someone as mad comes about. Ramolao and Hunadi both spoke about how killing other people using witchcraft leads to someone being punished to become mad. This occurs in contexts where the family of the victim(s) find out and want to avenge their deceased beloved one. The process involves consulting a traditional healer to curse that particular witch to become mad. Mental illness is associated with madness as a form of punishment for one's evil deeds.

> *"Most people here when someone is mentally ill, they think it is "revenge witchcraft" where one is punished for their practice of witchcraft through a curse, by becoming*

mad. They will call everyone to look at the person who has become mad as a form of punishment for bewitching others." Ramolao

"In the past, traditional healers would expose people who practice witchcraft. If they killed people. There were people, who were called mad or crazy which are those who got punished for their witchcraft and were cursed to be mad. You would find such a person in a kraal with lot of hair." Hunadi

Similarly, Mmamotse observed that a person can become mad because of witchcraft as a form of accounting for their own wrongdoings. However, in this case it is not because one has bewitched someone. Instead, stealing from other people is seen as a predisposing factor to becoming mad. This suggests that there are alternative ways of understanding how narratives of witchcraft are produced and for what purpose. In this regard, witchcraft does not only serve as a wrongful and injurious practice but also as a system of justice to hold those responsible for harming the community and others, consequently disrupting harmony and peace. This ensures that the perpetrators who threaten communal health are accounted for.

"There are people who steal from other people. One day they do that to a wrong person who knows a traditional healer. They will use muthi on him to go mad, then the person will start going up and down, not knowing what they are doing." Mmamotse

Hunadi further noted that *"... there is no crazy or mad person, there are all mental illnesses including those who used to practice witchcraft and got punished. You will not differentiate one who is mad and one who is sincerely mentally ill because of other stuff".* There seems to be a significant emphasis on the fact that there has been changes between the past and present. In the past, someone who became mentally ill because of their evil deeds would immediately be outed. However, the confusion is that there are no distinguishing indicators today to differentiate between someone who is genuinely ill and one who is mad because of punishment for wrongdoing. It is now a challenge in their communities to distinguish between the two. By listening to narrative and analysing stories, we are able to hear and see what has changed and stayed the same through time.

Moreover, just as madness is used interchangeably with mental illness, one participant showed that this is the same with *mafufunyana*. They are two labels used to ascribe meaning to the manifestation of mental illness in other people.

"Mental illnesses are sometimes explained as mafufunyana sometimes you will not know what the problem with a person is… Some will say that the person is crazy, some say that she/he has killed or eaten people." Tau

However, Mahlako, one out of the ten participants, refuted the label of "madness" as means to make sense of someone who is mentally ill. She contended: *"No, some of the people when someone is mentally ill, they would say that he/she is mad which is not true because they are not mad or crazy, they are just ill"*. This quote suggests that the label comes with stigma towards those who are mentally ill. Here, Mahlako does not attribute causation such as bewitchment but instead characterises the condition as illness. This illustrates that even though narratives of mental illness as caused by witchcraft are constantly reproduced in the villages of Limpopo, through time they have come to be contested by some.

Furthermore, the interchangeable names used synonymously with mental illness are understood to be accompanied by specific behaviours that the mentally ill exhibit. These behaviours are typically considered to be abnormal in the community. There are behaviours that are considered normal and abnormal in the two communities where the study was conducted. Kgalema explained that they would continuously observe a person who is under suspicion of exhibiting symptoms of mental illnesses: *"The thing is that the person would normally wake up early but that changes… We will take the child to a traditional healer and if they cannot…help, they will refer us somewhere until we get help and the child is back to doing normal things as before."*

Three participants shared stories about people who were considered to be acting out of the boundaries of what is considered normal in their communities. From the observations in the narrative excerpts below, the abnormal behaviours by those who are mentally ill can vary from one person to another. The people who conduct these behaviours are either labelled as mad in most instances and mentally ill at times. However, the following quotes by Hunadi, Mahlako and Makwetla suggest that behaviour is the determinant of how the community identifies a person who is mentally ill. What is considered normal and abnormal is context-bound and shared and is understood through narratives among the wider community. This underlines what behaviours are accepted, rejected, and integrated in the narratives of mental illness.

"There are some young men who build houses mhhm, beautiful houses to be exact. But they do not even have trousers to wear ehh, but they built beautiful houses and get paid

but they do not even have a trouser. Do you think the person is aware, they know what they are doing? They will just be walking around getting in other people's homes ehh and picking up trash and papers on the streets. That is someone, who is mentally ill… Someone once passed on the streets naked mhhm..." Hunadi

"Even now in Mabintane, people are struggling with this mental illness. There are some young men in Mabintane who who… one of them we found in the kraal sleeping one day butt naked. Mhhm, that is shocking coming from Mabintane. The person did not even know where he is, this is what we call mental illness… Mhhm, you could see that this person is mentally ill because no person would walk in a kraal and get naked and sleep if they are sane, you see that they are unwell." Mahlako

"You can see that she was mentally ill. There is another neighbour of mine who was also mentally ill and she would lock herself in her house and not allow visitors… They just bewitch them and then the person starts being abnormal and doing all sorts of things even beating you up in the house." Makwetla.

The participants suggest that a person who is mentally ill is described and defined by the abnormal behaviours they engage in. Based on their own experiences, the participants articulated how they come to say that a person is "mad" or has "*mafufunyana*" which are the terms used interchangeably to describe a person who is mentally ill in their communities. However, in their narratives it was evident that what they describe as abnormal behaviours by those who are mentally ill varies from person to person, time to time, and experience from experience. These behaviours among others include being violent, beating others, walking naked in the streets, running from home etc. But their descriptions commonly show that people who are mentally ill are usually significantly disorientated in terms of time and place.

5.3.2 Treatment and perceptions towards mentally ill people

Participants noted that some of the people with mental illness are treated well in the community while others are not. This is dependent on how they make meaning of a person's mental illness. In a case where one is believed to be mentally ill as punishment for their wrong doings such as for practicing witchcraft or theft, they are ill-treated. In cases where one is mentally ill because they are bewitched or getting old, they are treated humanely and helped by the community. Thus, this theme explores the two research questions. "How do older villagers in Limpopo make meaning of mental illness?" and "What do the narratives of older villagers in Limpopo reveal about their knowledges of mental illnesses?" This theme reveals that how people in their

communities usually treat those who are mentally ill is based on how they make sense of what mental illness is and the knowledge (s) they have about the phenomena.

Three participants stated that people in the community usually fear those who are regarded to be mentally ill, especially because there is suspicion and curiosity about whether or not the person is ill because they are punished for their wrongful deeds. To explain where the suspicion and fear towards those who are mentally ill comes from in the community, Kgalema said *"My sister, you cannot just touch someone who is mentally ill. People are dangerous other there. The illness might be passed onto you, your enemies knowing very well that you are a healer. They might set you up in that way. This illness can be infectious, that is magic"*. This suggests that it is not only fear of one who is mentally ill but also about others who might want to harm another person depending on their positionality and role in that community. This is based on the idea that things done through witchcraft are contagious if one is not cautious. Narratives allow us to understand a particular phenomenon or concept in relation to its cultural context. Here we see that Kgalema discusses mental illness in relation to fear and suspicion that are associated with cultural domains of healing and being a healer.

In cases where it is believed that the person deserves to be mentally ill, the community ill-treats them. This suggests that communities have ways of evaluating what one's illness means and how they ought to be treated in that context. This indicates that elders are open to alternative explanations and narratives of mental illness.

> *"They will hold the person and call their family to come get them. Helping the person is dependent on if you know the person and their family or if they ran away from home… They fear them and people even curse them because they believe the person is paying for their sins in other words." Hunadi*

However, even though Tau attested to Hunadi's preceding assertion, it is evident that there is compassion if the community makes meaning of one's mental illness as caused by another person or the illness is understood as heredity. If the person is understood as not having agency for their illness, the community works together to restore the well-being and mental health of that person. This is understood in relation to concepts such as communal health and ubuntu.

> *"If the person is mentally ill because of "revenge witchcraft" people fear that person, they do not even want to come near them and treat the person badly mhhm. But if it is someone who just got mentally ill or bewitched, they support and treat that person well*

and try to get them healed… when it is heredity, we do our best to get the person healed." Tau

Based on a personal anecdote below, Ngwato observes that sometimes the community might attempt to help a person with mental illness. However, if the person in question refuses the help, it is difficult for community members to offer their assistance as their efforts end up being in vain because the affected person would be resistant. This leaves feelings of helplessness and hopelessness due to a failed attempt to guide action to restore health and well-being of a person who belongs to a collective group. This consequently causes psychological distress and worry in the community.

"My own uncle once had mental illness and sometimes he would be okay and sometimes he would not be fine. You would think he is healed at times, to only find out that he is not fine mentally… I was still young. I would just see them trying to help him but he would refuse because he did not want to, hmm… The more they tried, the more he did not want them to. He would fight you if he knew that you are the one trying to help him. Ngwato

Furthermore, one participant showed that sometimes it goes beyond fear and issues of witchcraft as other participants have suggested. Makwetla contended that it is challenging to live with those who are mentally ill as they can be destructive to the whole community. This suggests that sometimes it is not that they are treated badly or stigmatised because they are not wanted in the community but rather that they pose a great danger to themselves and the wider community. When they are stabilised so that their behaviours are not concerning, they can be integrated into the community, welcomed, and treated humanely. Extending on Ngwato's assertion, Makwetla noted that should it be difficult for the community to help the person who is mentally ill, external help will be called in to intervene.

"We would live with them with difficulty because we live with them here in this village, we are used to the fact that sometimes they can be destructive and we call people of law to take them to facilities where they can get help. But when they come back healed, we live in harmony with them and we call them for any handywork we may have in our homes and they get to work..." Makwetla

In addition, Makwetla narrated a story where some community members in her village ill-treated someone who was mentally ill. This shows that even though there are some who stigmatise the mentally ill, from the excerpt below it is clear that some community members

have an understanding and empathy for those who are mentally and psychologically distressed. This story shows that ubuntu which aligns with empathy is not necessarily a practice followed by all. However, it does not mean it is absent in their sociocultural context.

> *"That person who came into my home who was mentally ill while my husband was not around, they treated him harshly and scared him. He then wanted to leave. I told my neighbours to leave right away and go back to their houses and let the poor person be… Some people do not accept mentally ill people the way they are they look at them some other way. But you can see that this person is ill and it is not their fault. No one would love to be in such state. No one would." Makwetla*

It is apparent that there is no consensus about the treatment of people with mental illnesses. Narratives are complex and put an emphasis on the role of context in how people narrate their stories. However, people who tell stories within the same or similar setting are not homogenous. This subtheme suggested that there are alternative truths and narratives regarding how mentally ill people ought to be treated in a certain context. However, communal harmony appears to be the most valued attribute in the villages to which participants belong. Mentally ill people who disrupt this harmony are treated as outcasts. However, the perceived cause of the illness is often a significant factor in how people are treated. Those seen as innocent victims of witchcraft are generally treated with sympathy and care while those perceived as agential and therefore as responsible for their own illness are often ill-treated.

5.4 Perceived causes of mental illness

Mental illnesses are attributed to different things which may vary from context to context, culture to culture and person to person. There seems to be no singular cause of mental illnesses. This aligns with the fact that narratives are plural with multiple meanings depending on the context they are produced in. The participants interviewed in this research acknowledged that mental illnesses are different and caused by various factors which are elaborated upon below. The main causes that were highlighted in the narrative accounts of the participants were: witchcraft, stress, food, and the use of mind-altering substances. This theme explores two questions of this research project as follows; "how do older villagers in Limpopo make meaning of mental illness?" and "what do the narratives of older villagers in Limpopo reveal about their knowledges of mental illnesses?" The theme engages how people make meaning of mental illnesses as well as the knowledges they have about mental illnesses which impact what they think the causes of mental illnesses are.

5.4.1 Witchcraft

Nine of the participants stated that in most cases mental illnesses are caused by witchcraft which is rooted in jealousy towards another person. The participants differentiated between a person who is bewitched to be mentally ill and those who are bewitched as form of punishment for practicing witchcraft and their own evil deeds. The excerpts below show how mental illnesses are understood as caused by those who do not wish the other person well and wish to inflict harm on their health and sanity. Jealousy or envy is understood to be aroused in someone when one person is observed to be doing good deeds. This leads to one being bewitched by the other.

> *"Some are caused by witchcraft mhhm. Yes, it is witchcraft done by your enemies for you to not make sense when you speak. You know people of our culture and what you are doing with me right now no one likes it… I have seen lot of people when they were mentally ill…even me, I have relatives who had mental illnesses and we took them to people to get healed. This is just all because of jealousy in this world."Mahlako*

> *"Mental illnesses mhhm I have been hearing about them…The thing is that most of them are caused by human beings it is not because they just come about naturally… they are caused by human beings because when you are just taking a walk by yourself, we put things on your path to trap you, so that when you are walking you catch the mental illness."Ngwato*

In addition to the witchcraft observed by Mahlako and Ngwato in the preceding excerpts, Hunadi referred to a phenomenon which is common in their community called "revenge witchcraft". This occurs when the person who once bewitched others gets cursed and exhibits behaviours that suggest mental illnesses. In past generations, this allowed people in the community to distinguish those who are bewitched for punishment for their past evil deeds and those who are just victims of the practice of witchcraft. A way to determine whether or not one is being punished or if they are a victim of witchcraft is to listen to what they say during the period of madness. Confessions among those that are mad as a consequence of punishment are reportedly common during this period.

"In the past, when someone suddenly just gets ill mentally, we would know that they bewitched someone and someone paid back, that they are a victim of "revenge witchcraft" as they are witches. You would find that the person will confess that she did this and this to Paledi's daughter. Because of their witchcraft they then got mentally ill. Some they are just bewitched and they lose their mind." Hunadi

In addition, Ramolao contended that causes of mental illnesses such as witchcraft are understood through cultural lenses. She observed that *"according to our culture some mental illnesses are because of witchcraft where one causes the other to be mentally ill"*. This suggests that in Pedi culture to which the participant belongs, witchcraft is conceived of as one of the main causes of mental illnesses. As elders, the participants could attest to the fact that before and since they were born, they have understood witchcraft as a cultural practice that is sustained intergenerationally.

"No, mhhm this something that has been happening for a long time. We just found things like "revenge witchcraft" existing." Mahlako

"I have explained that witchcraft is not something that is starting today, it has long existed just like a bible…They go way back; witchcraft has always existed … She is going to teach her child to come after yours. Witchcraft is a practice like church… it is intergenerational, a culture on its own... It will never become extinct." Kgalema

In the preceding accounts, participants are claiming witchcraft as a practice of worldmaking within the community. It is not foreign or strange but appears to be an important explanatory frame that enables communal meanings of life. It is understood as intergenerational and as encoded in cultural reproduction. In addition, the following narrative accounts reiterate the previous assertions that witchcraft is considered to be a significant cause of mental illnesses in the communities within which participants live. The excerpts suggest that those who practice witchcraft and inflict mental illnesses on others are identified as both men and women. The data shows that historically the practice of witchcraft was always understood through gendered lenses. The findings show that men are perceived as the main practitioners of witchcraft and that women often follow or learn from men.

"Yes, we should say this without doubt, we grew up with the notion that women know witchcraft best, they can be sent to bewitch someone but the leaders of witchcraft are men… Exactly! But there are women who are not led, they just know witchcraft and do not follow anyone." Tau

Tau's assertion that men teach women witchcraft appears to cancel itself out when he contends that women know the craft best and that not all women need the leadership of male witches. Two participants went on to also acknowledge that in terms of gender, there are no exceptions regarding who practices witchcraft. However, they did point out that women are more involved because of their "innate" characteristics, they are more likely to practice witchcraft. Women are regarded as innately jealous and dangerous beings.

"Men are the leaders and women are the distributors…Yes, but we emphasize on women because by nature they are very dangerous they do not have sympathy when they are fighting you, they become ruthless."Kgalema

"Its women and men… also men are involved… It is often women because women want to live alone and be by themselves and are jealous human beings." Mashego

While the statements differ in nuance, there appears to be some consensus that witchcraft is not gendered. The nuance believes gender stereotypes that attribute more jealousy to women.

Even though most participants attributed witchcraft as the major cause of mental illness, there was a single dissenting voice that observed that most community members in his village do not say a person is bewitched when they are mentally ill. In his account, villagers make sense of mental illnesses through different lenses as compared to what other participants have mentioned. In Lefokisi's view, *"it is not often that I hear them saying that when one is mentally ill is because of witchcraft."* In general, though, it is worth noting that village elders largely make meaning of mental illness through attributions to witchcraft. Notwithstanding its role as a deeply embedded form of cultural reproduction, since the practice is also seen as a threat to community wellbeing, it is understood as a significant cause of both mental and physical illness.

5.4.2 Stress

Five of the participants reported that stress is one of the main causes of mental illnesses. They argued that stress could build to a point where one ends up mentally compromised. The participants noted that stress builds up to a point where a person is incapable of coping emotionally. As a result, one's mental health starts to deteriorate. This consequently leads to mental illness. Participants asserted that to avoid this, people need to be able to be in a position where they can cope with the stressors of life so that it does not lead to mental illness. In the following quote, Ramolao provides an example of one of the behaviours that is usually observed in a stressed person. He notes that due to challenges in life people start talking to themselves and this provides a clue that they are mentally ill.

> *"Some become mentally ill because of stress…If you do not manage it, it will be a problem. You know when you have stress you become an ill person. So, a person must be able to manage stress so that they do not become mentally ill." Mamotse*

> *"Mental illnesses are caused by stress which shouldn't sit with you until mentally you are not functioning well. People overthink things to a point that they become mentally ill. The person will be talking alone about the problems he/she is facing (mhhm), this is stress which causes mental illnesses." Ramolao*

> *"We understand mental illnesses as caused by stress sometimes." Mahlako*

In addition to these attributions of stress as a causal factor for mental illness, Lefokisi spoke about stress by relating it to his own experiences. In his account, he noted that the role that he plays as a community leader can be challenging and thus stressful for him. This illustrates that certain experiences and life events which are regarded as stressors can predispose one to stress and mental illness should the stress be unmanageable and intolerable. Narratives are coherently connected to convey underlying meanings. It is apparent here that Lefokisi in the beginning of the story (first theme of the study) expressed his experiences of being a headman, and how it is connected to how he makes sense of what causes mental illness in the middle of the story. The beginning, middle and ending of a narrative are connected.

> *"The problem would be not feeling like you are leading well when other people destruct or become problematic in the community… You ask yourself until you lose out on sleep. You start to realize that you are losing your mind." Lefokisi*

Makwetla extended on the previous excerpt by reiterating that it is difficult for one to manage their own mental health while under stress. She noted that she has observed this with other people in which stress has been a contributing factor for the development of mental illness. There is an understanding that stress predisposes people to mental illnesses. What is evident here is that narratives are not always produced from first-hand experiences. The person who might be narrating the story might be someone who has observed other people's stories and experiences within a particular historical and cultural context.

> *"Mental illnesses most times are caused by stress, when you are stressing too much and your heart cannot find peace you can lose your mind. I have already seen this happening to other people." Makwetla*

The preceding quotes presented under this subtheme show that some elders from the two villages of Limpopo province strongly believe that stress due to various difficulties one experiences in life can put a huge strain on one's mental health to a point that they get affected mentally and fall ill.

5.4.3 Food and substances

Three participants contended that food could cause mental illnesses, particularly the types of food consumed in the present. They made a comparison between the food they used to eat in their youth and the type of food consumed today. This narrative tells us about the past, present and how the potential story about food and mental illness might unfold in the future.

In the excerpt below Mamotse observes that traditional foods used to keep them mentally healthy growing up. She noted the shift in foods consumed between generations. Whereas preceding generations of great ancestors ate traditional foods, she reported that current generations have substituted traditional foods with Western foods. Western foods are understood as being harmful to one's mental health. Participants observed that the high prevalence of mental illnesses in this generation is attributed to the unhealthy food eaten in this era. These foods go against what was healthy and aligned to their culture and traditions. For Mamotse, this means that there is a significant relationship between one's culture and tradition and food and this plays a significant role in maintaining mental health and serves as an indicator of whether one is at a risk of developing a mental illness.

> *"Mental illnesses are caused by the food that we eat now. We no longer eat traditional food that our ancestors used to eat… It is the food that we eat, yes, we do not eat our*

traditional food anymore, yes. We are looking at Western food and other cultures and this is problematic… the thing is the illnesses are more prevalent now because of the food that we eat… Western ways of doing things is not our way. Our way is our traditions and culture that we grew up with. When we used to make food like porridge ourselves and eat peas even now, I still do." Mamotse

Moreover, Ramolao noted that with technological advancements, foods are being processed as a means to preserve them for much longer. Efforts undertaken to achieve this goal come at a cost as the preservatives added to the foods compromise our mental health. Hence, Ramolao argues that food exposes us to the possibility of developing a mental illness. Moreover, Ramolao points out that the modern era, which is guided by Western way of living, with an example of the kind of foods that are predominantly eaten today, is welcomed with suspicion. This narrative might draw back to what "Western" represented in the past for the older generation and how the narratives about westernisation of things such as food elicits past feelings and memories that linger today.

"Now mental illnesses are caused by food we eat… All these foods that we eat, they put pills in it, from sugar, flour etc. This is because they do not want the food to go to waste quickly, milk and mageu, they have things inside them…" Ramolao

While Mashego seemed a little bit uncertain about what could be the cause for mental illnesses, she shared some insight about what she thinks might be one of the causes of mental illness. She corroborated what the other participants said about living in a society and generation where cultural foods such as peas and beans which were previously considered to be staple foods are not eaten as before. She noted that this could help explain the causes and prevalence of mental illnesses today.

"Yes, I do not know what causes them, maybe it is the food that we eat now because we do not eat cultural food anymore. So, we cannot be sure about what causes these illnesses we just see people having them…when we eat our cultural food, we do not get sick… we are healthy when we eat peas, porridge, beans, morokgo. However now we do not do that anymore." Mashego

The three participants cited above argued that the foods that people eat today are not healthy for the mind nor the body which consequently impacts people's mental health. For example, Ramolao observed that processed foods that are meant to stay longer have negative effects on one's mental health as compared to traditional food that elders used to eat in the past. These culturally based foods include peas, morokgo and beans. Mashego and Mamotse categorized these traditional staples as healthy.

In addition to unhealthy diets, some participants stated that substances such as drugs and alcohol cause mental illnesses. The following quotes show that there were elders who strongly believed that drugs pose a huge negative impact on a person's mental state when abused, especially among young people of the current generation. The excerpt below suggests that substance use is understood to be more prevalent among the youth as compared to the elderly, which consequently puts them at a risk of developing mental illnesses. The substance "nyaope" is considered to be mostly used by young people which then puts them at the risk of having mental illness.

> *"In most cases older people who are mentally ill is because of witchcraft but that is not the case among the youth. It is just like that maybe it could also be because of drugs, when one abuses drugs of certain kind and when you look at their face you can see that they are not okay. These kinds of people use nyaope and you can see that they do not like water and do not even eat… these days is that when you go consult you find that the person is actually fine the problem is the drugs they are using." Lefokisi*

> *"There are drugs called nyaope, they cause people to be mentally ill." Kgalema*

Moreover, Hunadi supported this line of attribution by observing that young people are exposed to a life of drugs which explains the manifestation of mental illnesses among this group. Drugs are considered to have a significant impact on the mental functioning of the youth in particular. This shows that some elders in these communities might be aware of the negative impact drugs have on a person's mental functioning and how they use that to explain mental health and how mental illnesses comes about among the youth. Hunadi explained that *"people steal cows and drugs; the same drugs that cause mental illnesses. Most young people are mentally ill because of drugs."* Here, Hunadi makes the link between substance abuse and stealing to fuel the habit. In rural areas, the theft of cattle is partially attributed to substance dependence. In rural

communities that practice decolonial ethics, there ought to be a balance between the people, non-living, plants and animals. Hence, when one steals a cow, that may be understood as a direct threat to the balance and harmony in the community. In addition, Tau observed that there has been a shift in how the causes of mental illnesses were understood in previous generations as compared to today. *"Just that in this generation people are also affected by the drugs that they take. These drugs also cause mental illnesses."* This suggests that perhaps the use of drugs was not as prevalent among previous generations. However, with the observations that the youth are using drugs which consequently adversely affects their mental well-being, the elders have come to think of them as problematic when advocating for youth's mental health.

In addition to drugs, Lefokisi observed the effects of alcohol as follows: *"Most of the people here think mental illnesses are caused by alcohol which shows when someone no longer makes sense when they speak or the drugs."* The easier proliferation of drugs and alcohol in the present together with high unemployment means that these substances are used as a means of dealing with current stressors. This consequently leads to a higher prevalence of mental illnesses.

5.5 General healing systems of mental illness

This theme addresses the following research questions: "What do the narratives of older villagers in Limpopo reveal about their knowledges of mental illnesses?" and "what are the various health care healing systems that older villagers in Limpopo seek help from for mental illness?" The narratives about healing practices for mental illnesses extending to physical illnesses reveal the knowledges that the participants have about mental health services in their communities and how that affects where they seek help. The theme also explores the various healing practices present in their socio-cultural context. The healing practices that the participants narrated in their stories also taps into one of the research questions that asks how elders of Limpopo make meaning of mental illnesses. How they make meaning of their illnesses often influences how and where they seek healing. Thus, this theme accounts for all the three research questions through the subthemes discussed hereunder.

5.5.1 Indigenous healing

All the participants noted that when one is mentally ill, they seek help culturally, religiously, and traditionally. For the participants of this study, the church and traditional healers are key sites for healing mental illnesses. For example, Kgalema observed that even though there are

traditional healers who are available and accessible to heal illnesses, the processes used to heal a person might be different depending on what kind of illness a person presents with.

> *"Healing the person is not a problem, there are traditional healers. I am not one but I can give advice on how one can get healed. The healing process might differ from one illness to the other… according to me a person will heal using tradition or religion." Kgalema*

Another religious participant asserted that religious and traditional healing practices can be used and are beneficial in healing mental illnesses. The participant acknowledged that she is a member of a certain church and often consults religious healers. However, her close relatives have sought help from traditional healers whom she recognised as being competent when it comes to healing mental illnesses. Mamotse, who is a traditional healer that works with children health reported that even though she uses traditional herbs, she can acknowledge that churches do heal those with mental illnesses. She observed this in church before she was initiated into traditional healing. This shows that even though the participants may prefer one healing practice over the other (traditional or religious), they can still acknowledge the effectiveness of each based on the experiences they have had. Rather than seeing them as contradicting, these healing systems are seen as coeval and perhaps as complimenting each other.

> *"The thing is everything is up to God's will my child... there will be one who will be taken to traditional healers and when they get there, he will engage in the healing process using relevant herbs then get healed… Yes, it is church then traditional healing which is our culture. Traditional healers can heal mental illnesses, they can… Yes, I attend church but my family do not and they sometimes face difficulties and get help from traditional healers." Mahlako*

> *"Churches, they do help with some things because I started healing babies when I was still attending Zion church without using traditional herbs." Mamotse*

Hunadi also attested to the fact that churches and traditional healers are capable of healing mental illnesses.

"Yes, through church and traditional healing one can get healed. At church, the healing process might differ from one person to the other. People are given the power to heal others." Hunadi

Ramolao further noted that healing a person who is mentally ill will depend on the healer's competence to select appropriate herbs for the process: *"Mental illnesses can be healed by a person who really knows the kind of traditional herbs to use for healing them."*

The preceding quotes show that traditional and religious healing practices are commonly used in the villages of the province of Limpopo. It appears that traditional and religious healing practices are the primary healing systems that people first approach when ill, whether mentally or physically. However, even though traditional modes of healing are commonly used, there seems to be a conflict as some participants expressed their concerns and mistrust towards the traditional healing system. These contentions are engaged below.

The participants compared the effectiveness of traditional healing practices of the past to those of today. Three of them argued that they had noticed major changes in the traditional healing system over their lifetimes. These changes have built mistrust, suspicion, and concerns towards traditional healing practices in general. In the following excerpts it is apparent that some participants are questioning the practice because of how traditional healers of today prioritize money and do not respect the preservation of traditional herbs. In addition, Ramolao raises an issue of greed and exploitation of traditional medicine that was not prevalent in the past.

"Traditional healers of the past would not dig lots of herbs like the ones of today. What they dug could fit into a pocket of a trouser, mhhm they were not a lot. My brother-in-law was a traditional healer so I would go with him to dig traditional herbs. Today, they dig a lot of herbs that is why they are not working because they are not supposed to do that… Also, traditional healers of the past did not prioritise money." Ramolao

"Traditional healers of today are only interested in money but no they cannot heal people… in the past they would heal people, they would say that only when the person is healed you will pay, mhhm, and the person would definitely get healed." Makwetla

"But now traditional healers prioritise money over anything. Before they even start the healing process, they will ask you to give them this much." Mamotse

These participants object to the environmental degradation of over harvesting medicinal plants and they see the practice as financially exploitative. Additionally, Hunadi expressed her mistrust towards traditional healing by observing that healers of today are too young in comparison to the ones of the past.

> *"Traditional healers these days are young as compared to the past… There may be some who still have some power but I have never seen them these days. I have never heard someone saying this person was sick and got healed by this traditional healer… When someone is sick, they always think the person has an ancestral calling and must be initiated into traditional healing…now everyone is a traditional healer." Hunadi*

Hunadi adds that claiming traditional healing skills results in everyone being recognised as having an ancestral calling. This proliferation of healers makes it hard for people to trust their ability to heal illnesses. The excerpt suggests that because of how things have changed, there are no proper processes put in place to evaluate whether or not a person sincerely has a calling. People are mistrusting and questioning if there are traditional healers powerful enough to heal others.

5.5.2 Western healing

While some participants strongly emphasised the use of traditional healing in the previous subtheme, this was not to the exclusion of Western modes of healing. Some participants contended that Western modes of healing for mental illnesses are beneficial. For instance, Ngwato narrated a story about his relative who made use of Western modes of healing and was healed. There is an understanding that when people are mentally ill, they can seek help through Western healing systems such as hospitals which are perceived as beneficial.

> *"People get healed at hospitals. My uncle was healed at a hospital because that is where people go when they have mental illness… Yes, he was much better when he went to a hospital…he was doing much better, he was much better indeed… It was Western medicine because that place was a hospital." Ngwato*

Similarly, Mahlako pointed out that when people are sick, they can reach out for help to get healing through hospitals. A hospital is identified as a mental health service and resource that is available and accessible for those who are mentally ill. *"Where they look after mentally ill people is at hospitals...hospitals in Rankuwa are looking after mentally ill people."* In addition,

Hunadi explained how people get healed at hospitals for illnesses that they may present with at the time by stating that *"some people get healed at hospitals and clinics. The pills they are given do heal them… People should not forget hospitals when they are physically or mentally ill because the medication does help them to feel better"*. These excerpts suggest that people should keep in mind other healing systems that might be available to assist with illnesses. There seems to be some acknowledgement of Western healing services that might aid people in the community.

However, just like in the case of traditional healing some participants expressed their mistrust towards Western healing systems. Ramolao pointed out that it would be problematic for one to seek out healing for mental illness through Western systems. He specifically stated that *"They can't heal some illnesses, especially the ones we are talking about… Most illnesses caused by witchcraft they cannot heal… They will give you an injection which means after that no traditional healer will be able to heal you"*. There appears to be a belief that traditional healing should be sought first, particularly if the mental illness is believed to be caused by supernatural phenomenon such as witchcraft. Also, the methods of Western healing are seen to do more harm to the person, exacerbating the illness. In addition, Kgalema noted that the mistrust towards Western healing is because of the money that is required for one to get healed which signals a shift when compared to how things were done in the past.

> *"No, in the past we would go to a hospital and get healed regardless of the illness one has. But today, you are just looking for money."Kgalema*

Tau went on to make a comparison between traditional and Western healing in which he reported that if one opts for the latter, they will not be completely healed. It is only when one follows the cultural and traditional healing practices that their mental health can be completely restored. In the following quote, Tau suggests that there is a belief that Western healing can provide healing to a certain extent. *"Ehh, thing about clinics and hospitals, let me just say, Western medicines in short do not heal a person completely they just make you feel better. But with traditional healers of our culture, they do heal you completely."* The scepticism towards Western modes of healing comes from the belief that they are not good enough and inclusive of the cultural and traditional aspects pertaining complete health. Complete health is equated to community wellbeing. Western medicine is perceived to treat the symptoms but not attend to the underlying issues.

5.5.3 Integrative healing

Four participants believed that both traditional and Western modes of healing are beneficial for those who are mentally ill. In the previous subthemes, one healing system was prioritised over the other with some scepticism based on different reasons towards both healing systems used in the participants' communities. However, some participants emphasised the importance and benefits of both the healing systems when used holistically. Participants stressed the fact that making use of different healing systems in an integrative manner is important when one is faced with illness. The excerpt below suggests that the participant acknowledges multiple forms of healing and believes they can be beneficial when integrated. However, it was noted that the first service to be contacted would be a hospital.

> *"Hospitals do help as you see us now, we are taking treatment at clinics to extend our days of life on this earth… while traditional healers they are also here and can be of use for your family, also churches can help… Ehh, traditional healers and churches can help you…but before I go to them, I must firstly consult at a hospital." Lefokisi*

However, in contrast to Lefokisi, Tau stated the following, *"I have a little bit of experience in traditional and religious healing. In most cases, people do get healed. If not, we will take you to a hospital but according to me a person will heal using tradition or religion… If you have not healed after 8 months, we take you to Western facilities"*. He sees traditional healing as the first port of call for those needing help. Even though the two expressed differences in how they narrated their stories regarding where they would seek healing first, there seems to be consensus that should one healing system not be able to help or heal a person another alternative healing system should be explored.

Mamotse acknowledged that Western healing might not necessarily heal a person completely. This would mean the alternative would be taking both the traditional herbs and medication given at hospitals. The excerpt below suggests that two different practices of healing can be integrated for the betterment of one's health.

> *"When they give me a date, I go to collect the pills… You find someone at the hospital who really cares about the well-being of the patients and would tell you that while taking the pills also take your traditional herbs. Because the Western medicine does*

not completely heal a person, it just eases the pain but you must drink your traditional herbs some other days." Mamotse

Ngwato, a pastor, referred to Moria, the headquarters of Zion Christian Church (ZCC) located in Limpopo.

"When we go to visit Moria with our transport, we wait at the main gate and we are asked questions about whether we are with a person who may be sick to a point that they will need clinic services or pills. If that is the case, they tell us that they have a clinic that can help." Ngwato

Ngwato's account suggests that there is room for integration because religious healing systems like ZCC have integrated Western healing practices. There appears to be an acknowledgement of the mutual value that various systems of healing have. Collectively, these narrative accounts suggest that rural communities in the Limpopo province are aware of both the Western and traditional mental health services that they can access and make use of. These are either used in parallel or sequenced based on people's beliefs. There was however some suspicion based on perceived changes related to the costs of healing and the financial motives of healers.

5.6 Summary of findings

Narratives presented in this chapter are telling about the past, present and the future with regards to the understandings and meanings of mental illness. The research found that all the participants understood themselves to be playing significant roles in their communities. They saw these roles as difficult and often found themselves as arbiters of conflicts in their contexts. As elders, they understood their roles as ensuring a balance in the community, where harmony, peace, and health (physical and mental health) are maintained in the interests of general well-being. In this context, community well-being is about balance and connectivity to the past through intergenerational transmission of memory and knowledges. The elders play a crucial role as the hinge to this past.

The research found that some elders in villages of Limpopo seem to hold varying and similar perceptions and beliefs regarding how they make meaning of the causes as well as the healing practices of mental illnesses. Their understandings of definitions and causes of mental illnesses appear to be culturally encoded and traditionally bound. It appears that the elders make meaning of mental illness as a condition that is manifested through a person's loss of contact

with reality. A person is identified to be mentally ill through behaviours that are considered abnormal by community members and in the community.

Mental illness was understood by the elders to be a result of various causes which included witchcraft, lot of stress, unhealthy food, and substance abuse. They contended that there are instances where one is bewitched to be mentally ill. There could be two reasons for this; either the person is bewitched out of jealousy for what they have or as a form of punishment for their evil deeds. This defines how they are perceived and treated by other community members. While some are treated well and assisted, some are stigmatized especially in the case where it is believed that the person who is mentally ill is a witch that is being punished for their sins. The findings suggest that the majority of the elders believed that both men and women practice witchcraft. Gender was found not to be an exception in this instance. However, women were deemed to be more likely to be involved in the practice when compared to men. It appears that witchcraft is an important means of cultural reproduction and meaning making in village life. In this regard, participants understood the practice as a part of life that predates them and will always be a form of community regulation. In addition to witchcraft, stress was conceived as an important factor in causing mental illnesses. The elders further differentiated between traditional and processed foods and the impact they have on one's mental and physical health. In this regard, traditional foods were seen as healthy while processed foods were understood to be unhealthy and as responsible for higher incidences of mental illness. Lastly, substances such as drugs and alcohol were identified as a significant factor in relation to the manifestation of mental illness among the youth.

Lastly, the participants identified three healing systems that people often opt for when they are mentally ill. These systems are traditional, Western, and integrative. In some instances, people would go to traditional healers or churches for healing while some would go to hospitals and clinics. However, some participants advocated for the use of both traditional and Western modes of healing. It was apparent that there is some mistrust towards both systems regarding their effectiveness and authenticity. They generally found them less efficacious than they used to be in the past. This suggests that community members in Limpopo are amenable to working collaboratively with various healing systems embedded in their communities while critically questioning their efficiency and effectiveness. The findings from this research suggest that elders can identify people who are mentally ill and the form of healing that might be beneficial. Identification of illness and the resulting modalities of treatment are generally understood in

relation to a broader paradigm of community wellness and the stock of community wisdom associated with elders.

CHAPTER SIX

DISCUSSION

6.1 Introduction

This chapter discusses the themes outlined in the findings chapter by relating them to literature in the field and decolonial and narrative theories that underpin this research. The chapter discusses the findings of the current study with regards to the following themes that emerged from the narrative accounts of elders from two villages in Limpopo. The themes cohered around the following nodes: elders' roles in the community, older villagers' meaning making of mental illness, perceived causes, and healing practices of mental illness. The aim of the study was to explore and shed light on the knowledges and meanings of mental illness or psychological distress and healing systems from the perspective of the narratives of older villagers. Thus, the following research questions were addressed by the study.

- How do older villagers in Limpopo make meaning of mental illness?
- What do the narratives of older villagers in Limpopo reveal about their knowledges of mental illnesses?
- What are the various health care healing systems that older villagers in Limpopo seek help from for mental illness?

6.2 Discussion of the findings

Story telling does not only help us learn and understand precolonial and colonial histories and legacies (Kovach, 2015), but also allows indigenous people to remember, connect, celebrate, and regenerate their experiences. The narrative approach of this study afforded the elders an opportunity to make sense of their experiences, to surface and share their wisdom, and to articulate paradigms of wellness and healing that are rooted in their context and accumulated knowledges (Kirmayer et al., 2011). This aligns with Gonzalez-Rico and Fuentes-Pineda (2018) who argue that indigenous people have many stories to tell about healing, resilience, and health. The first theme of the findings focused on the narratives about the roles elders play in the villages of Limpopo. According to Gonzalez-Rico and Fuentes-Pineda (2018), through a narrative approach, people are able to tell stories about who they are, what they do and where they come from, what they could be and the great experiences they have gained throughout the years they have lived. These are called first-hand stories by Akhinsanya and Bach (2014). First-

hand accounts enable people to share their own experiences in a particular historical and cultural context. Thus, the narratives shared by older villagers in this study reveal their cultural, social, economic, and historical background (Gonzalez-Rico & Fuentes-Pineda, 2018). The beginning of their stories started with who they are, the social roles they play and related them to how they make sense of mental health and illness. Narrating a story involves showing how things are connected in various ways while giving the reader a sense of where it begins, as well as the middle and end (Dein, 2016). Therefore, while the study had a particular focus, the narratives spilled over into whole lives and participants shared their histories, anxieties about the present and hopes for the future. These narrative leakages were important for situating the meaning making of participants in relation to issues of mental health. Following a narrative interpretation, stories particularize one's experiences and are a starting point for understanding how those experiences are socially and culturally constructed (Godsoon, 2013). Through telling stories, elders can establish sense of self and organise their experiences (Kugelmann, 2001). Through their narratives about which roles they play in their communities, they establish their identity. However, Moen (2006) argues it must be distinguished that in narrative research, the findings presented in the report are a representation of the elders' lives within their roles (e.g., as a pastor, traditional healer), but not their lives as experienced or lived. While this distinction is important to hold in mind, clear delineations between the psychological and social are not entirely helpful. Thus, even as we talk about aspects of our lives, we unwittingly tell fuller stories that are always grounded in place, experience, and socio historical contexts.

The study found that elders in the villages of Limpopo play an integral part in their communities. They play various roles, from being religious and traditional leaders and healers to youth advisors. It is evident that elders in their communities play significant roles in acting as a supportive structure for their community and its members, encouraging support and mental health (Sehoana, 2015). Elders occupy a place of respect, and they see themselves as the connective link to the wisdom and knowledges of prior generations and ancestors. They fulfil their roles, observe the world, and intervene from this location. In some respect then, they see themselves as practitioners of community wellness. Decolonial theory asserts that past traditional elites which were recognised as elders in most African societies formed a foundational basis for knowledge production and cultivation as well as health (Ndlovu-Gatsheni, 2018). The stories shared by participants are telling regarding the purpose they serve in their communities through the experiences they have had. Here, we might see the elders' narratives as interventions against the destructive effects of colonial modernity. For instance,

their assertions that change in diets are detrimental to community and that over harvesting of traditional herbs degrades the environment are important decolonial tenets that centre traditional and community knowledges of wellbeing. Thus, elders reclaim indigenous epistemologies and practices (Sium & Ritskes, 2013). In this vein, Chirimuuta and Chirimuuta (2012) contend that collecting historical and cultural knowledge about Africa from elders encourages decolonial thinking. Conceived of as a liberation and decolonial method, storytelling by elders connects the past with the present and future as well as connecting the personal and the cultural to seek meaning regarding how they understand health and mental illness (Stevens et al., 2013; Bell, 2010).

The findings of this study resonate with those carried out in other indigenous communities. For example, an Australian study found that elders play a significant role in maintaining community health and passing on knowledge to younger generations. Moreover, another study carried out in Ethiopia and Canada found that elders resolve conflicts and maintain peace as well as psychological well-being in their communities (Viscoligliosi et al., 2019; Mohammed, 2018). This resonates more with the finding of the study where participants such as the headman plays a leadership role in his community. He observed that one of the responsibilities that comes with the role entails resolving conflicts in his village and ensuring that peace is maintained. This can be traced back to the pre-colonial era where elderly men formed advisory councils that advised people and ensured that there was communication between chiefs and villagers (Ayittey, 2010). Elders look beyond their individual well-being to ensure that peace, health, and harmony is maintained in their communities. This suggests that mental illness and health is not only understood in relation to self only but to the collective wellbeing of the community (Gergen, 2015). Conceptualized broadly, community wellbeing prioritises the community holistically (King et al., 2009). Some elders appeared to carry the strain of responsibility by embracing their advisory, counselling and healing roles despite the stress that accompanies this work.

According to Mohammed (2018), elderhood in Africa is practiced through the cultural concept of ubuntu where elders ensure that there is a balance and coexistence between the spiritual and physical world. Makhubela (2016) argues that understanding concepts such as ubuntu or communality is central in African societies as this helps us to understand what health is and how it is maintained. While participants did not directly name ‘ubuntu’, the spirit of respect and care that imbued their narratives suggests this ethic. The ethic of care was simultaneously a preventative strategy and a form of healing. To care for people is to provide council, appease

ancestors and not wish ill on others through witchcraft. It a practice captured in an old woman's story of stopping people from violently ejecting a mentally ill man from her home. It is also represented by acts such as providing employment through handiwork to those recovering from illness. The praxis highlighted in this suggests that if we are to practice African psychology to address mental illness among Africans, we must understand how people make meaning of what constitutes illness and wellbeing within the context of an ethic of care encapsulated in the practice of ubuntu (Ratele, 2017). King et al. (2009) argues that it is important to consider historical events that have led to communal trauma impacting indigenous health. Hence, roles that elders play gives an opportunity for reparation and strengthening traditional structures to improve well-being and health of indigenous people.

Older people are not only called elders on the basis of their age but are recognized as citizens that the community reaches out to for guidance (Eades et al., 2021; Nhongo, 2004). Lewis (2011) notes that the roles that elders play are based on wisdom, emotional and physical well-being, spirituality, and community engagement gained through life experiences. This was evident in this research where it was found that the narratives that the elders of Limpopo shared are based on their experiences about their culture, community, religion, and spirituality. Interestingly, among the participants were traditional healers, religious healers, religious and community leaders. This suggests, that elderhood appears to come with expectations of stewardship of community wellbeing. For Mohammed (2018), African elderhood involves multifaceted milestones in which a person goes through stages that equip them with knowledge about health, peace and community customs that are passed on between another generations. For example, one of the participants was a youth advisor. He observed that the role that he plays in his village allows him to pass on the knowledge he has acquired from deceased elders about healing, mental and physical health to the youth. Similarly, Michel et al. (2019) argues that elders share a large body of skills and knowledge regarding illnesses and herbal treatments particularly in rural areas. They are not only teachers but knowledge keepers (Mohammed, 2018; Nhongo, 2004).

Some scholars have argued that with rapid urbanization and assimilation of indigenous people, there has been lack of intergenerational connectedness and loss of traditional ways of living. This consequently erodes the roles of elders in society. Moreover, others have argued that as African countries and their people move towards modernization, the narratives about health are often individualised following a Western approach that prioritises the individual over community and tradition (Goodson, 2012). In Africa today, traditional systems of living and

elderhood have drastically changed due to Western legal and governments systems, Western education, and introduction of new religions (Mohammed, 2018; Nhongo, 2004). This leads to elders being perceived negatively and their roles as well as status being undervalued (Nhongo, 2004). This was evident in the study where some participants stressed out that the youth undermine the significance of elders' roles and past traditions in their communities. It was therefore necessary to understand the contemporary roles of elders as they are located as a hinge between previous and current generations. The current study found that village elders still perceive themselves as valued and problems pertaining to health are often addressed by them before those needing assistance are taken to Western institutions. The elders observed that they do not only assist their communities but other people outside the community to ensure that there is stability and harmony. The systems used to select the appropriate elder to undertake certain problems are African based which means they are established in relation to the norms, values of Africans and their context (Attiyey, 2009).

The second theme in the findings chapter explored how elders in Limpopo make meaning of mental illness. It found that mental illness was understood as madness which manifests in the form of abnormal behaviours, and this impacted how the person was treated in the community. The concept of madness has long existed and evident in all cultures (Fernando, 2017). Akomolofe (2012) has argued that socially incongruent behaviours, mental illness, and normalcy are understood through different lenses by different cultural groups. The way that people adhere to cultural rules or beliefs when trying to make meaning of mental illness is constituted through narrative and that is how they communicate their cultural identity to the listener (Bruner, 1991). This perspective about mental illness understood as madness is informed by cosmologies and paradigms that locate the narrators in storied relation to others, self, and their socially constructed world. Mental illness as madness correlates with the genealogies of mental illnesses. Porter (1987) defines madness as a "generic name for the whole range of people thought to be in some way, more or less, abnormal in ideas or behaviour" (p. 6). This coincides with the cultural syndrome called "amafufunyana". Thus, the findings showed that "amafufunyana" which in English translates as madness; these two concepts are used interchangeably and analogously in most African contexts (Matsumoto & Juang, 2016). Around the 19th century when Western models such as the DSM were non-existent, people were labelled as "mad" "lunatics" (Gillis, 2012). However, this has slowly faded due to the introduction of Western diagnostic models. The findings suggested that mental illness understood as madness is still predominant in some of the villages of Limpopo. Through

engaging with the narratives presented in this study it is evident that as people our understandings and knowledges are linked to some historical and cultural conditions that inform our identities and knowledge.

Mental illness as madness is perceived as a socially constructed label based on the definitions and descriptors of normality (Ussher, 2014). There is what is called the "symptom pool" which is understood as a legitimate group of symptoms of madness or illness peculiar and particular to a specific culture at a certain point in time (Ussher, 2014; Ventegovel et al., 2013; Mokgobi, 2012). Furthermore, by asserting that one is mentally ill or mad, we attempt to decide what is considered "normal" consequently perpetuating what is perceived as desired behaviour(s), feelings, and thoughts in a certain context. There is stigma associated with being mad. Research has found that people are not necessarily ill-treated or stigmatized because they are mad or mentally ill but based on how their immediate community and family make meaning of how they have come to be ill (Leff, 2014). Mashumoto and Juag (2016) similarly argued that culture plays a pivotal role regarding how community members come to understand mental illness as well as how they treat the person who is mentally ill. Ussher (2014) echoes this by stating that traditional dialogue about mental illness, or madness follows a specific criterion to warrant the person as a victim or perpetrator of witchcraft. Moreover, echoing Chikaodiri (2009) and Ranguram et al. (2004), the study found that people who are mentally ill are perceived as being a threat to themselves and their communities. The current study found that if it were believed that someone is mad or mentally ill because they were cursed for their evil doings such as witchcraft or punishment, they would be stigmatized in the community. Studies done in African communities have found similar results whereby community members stigmatized those who are mentally ill because they were believed to be witches (Richman & Hatzenbuehler, 2014; Ssebunnya et al., 2009; Nyati & Sebit, 2002). However, the research found that there are some instances where the community help a person who is ill to restore their health. This suggests that ubuntu is something that is practiced in the community. It has been argued that ubuntu discourages stigma and ensures that people live in harmony with each other in the community (Engelbrecht & Kasiram, 2012). Decolonial and narrative theories assert that if we are to understand how people in Africa produce and reproduce knowledge, we must be willing to understand their ways of living and how concepts such as ubuntu help them understand political, health and social issues in their sociocultural contexts.

Through participants' narratives, we can see a link between the past and present. It is evident that the historical understandings of mental illness are still intact today. While there is an

ongoing narrative about mental health illiteracy in Africa, especially in rural areas such as those the research was conducted in (Schomerus et al., 2015; Egbe et al., 2014), it is apparent that elders in Limpopo carry cultural and historical knowledge and meanings about mental illness. However, Western notions of mental illness and health are more privileged while indigenous perspectives are undermined and marginalised (Greenwood et al., 2000). Thus, a single story about mental distress and health is continuously perpetuated. Narrative and decolonial approaches look beyond the single story by encouraging understandings of alternative knowledges or truths. This ensures that there is a diversification in knowledges of mental illness and health. Hermandez- Holf (2011) asserted that narratives from indigenous people about how they make meaning of mental health and illness must be grounded in a decolonial paradigm. These narratives need to be utilized by those who are working with diverse groups involved in practicing, theorizing and consuming knowledge about mental illness and health.

Furthermore, the third theme in the findings focused on the perceived causes of mental illness. The older people's narratives revealed that it is believed that witchcraft, food, substance abuse and stress are the common causes of mental illnesses in their villages. Almost all the participants pointed out that witchcraft is known as the common causal factor of mental illness in their communities. This correlated with a number of studies done in Africa that highlighted that external and spiritual forces are often used to make meaning and understand physical and mental illness (Lombo, 2010; Mashamba, 2007; Manyike & Evans, 1998; Tsa-Tsala, 1997). Mokgobi (2012) observes that narratives of witchcraft as a causal factor for mental illness have always been there but are often dismissed and untapped in literature. To carry out the decolonial project, we must abandon the mindset of understanding things such as mental illness from a Eurocentric perspective because the practice of witchcraft has long existed in pre-colonial societies and even today (Ratele, 2017). This was also emphasized by the participants in this current study. In contrast to extant literatures that argue that witchcraft is gendered as a woman's practice (Kounine, 2013), this research found that both men and women are believed to be involved in the practice of witchcraft. However, women are perceived as more dangerous because they are stereotyped as "innately jealous, spiteful etc". This illustrates that narratives about witchcraft are constantly reproduced in relation to how mental illness is understood and manifested in African contexts such as in Limpopo. Makhubela (2016) argues that to say that a concept such as witchcraft is uniquely African would be misleading. According to the perspective of decolonial and narrative theories, social pools of knowledge about witchcraft and other causes of mental illness are gained through a person's upbringing within a

community and are communicated through actions or words. This consequently informs a person's beliefs and identity (Purkhardt, 2015). However, aside from witchcraft, studies by Juma (2011) and Uys and Middleton (2010) found other cultural causal factors such as disregard for cultural norms and spirit possession to also play a role in manifestation of mental illness. This explanatory frame did not emerge in this study.

The inability to cope with heightened stress as a cause of mental illness emerged as a causal factor in this study. Uys and Middleton (2010) note that a stressor is experienced when a person is overwhelmed with challenging circumstances. Similarly, a study conducted in Limpopo among psychologists found that stress is one of the predominant causes in the manifestation of mental illness (Sehoana, 2015). Additionally, a study conducted by Shai (2012) in Limpopo among Pedi speaking participants and Mpumalanga by Sorsdahl et al. (2012) found similar results. In most cases, it has been argued that some people might not have protective resources to cope with the strain that comes with stressful situations which consequently leads to psychological distress and problems. However, undertaking narrative and decolonial approaches means that even though stress might be a universal concept that applies to various diverse contexts globally, it ought to be understood contextually because what it means in one context such as Limpopo might not mean the same in another (Perterson-Lund, 2011). By adopting decolonial and narrative approaches, we abandon a singular Western definition of stress.

Furthermore, based on elders' accounts, the study found that substances also account for the manifestation of mental illness especially among the youth. Some studies have corroborated this and further argued that abuse of substances such as drugs and alcohol lead to severe consequences beyond damaging the health of the user but also result in various mental health problems (Wani & Sankar, 2016; Claro et al., 2015). From a biomedical Western perspective, drugs have been documented to be significant in causing mental illnesses, such that in one of the diagnostic models there is an inclusion of substance-related disorders. The narratives of elders suggest that they see the detrimental effects of substance abuse in their lived experiences within their communities. However, their stories are often unheard and silenced. The value of narrative studies with the aged is that they surface silenced and ignored wisdom based on grounded experiences of everyday life. Participants in this current study referred to alcohol and nyaope as common substances that have been observed to be derailing the youth in their communities. Substances such as nyaope and alcohol have shown not to only pose risk for the abusers for developing mental illnesses, but also argued to cause conflicts in families and

communities (Nkosi, 2017; Masombuka, 2013). In most instances, communities and families are left distressed as the abuser ends up stealing and committing crimes consequently disrupting a balance of harmony, peace, and their mental health. Since health is understood within a holistic frame of community wellness, substance abuse is perceived as a threat to general community wellness beyond health.

Furthermore, some participants stressed the role of Western food in the manifestation of mental illnesses today. Some decolonial theorists argue that these knowledges have long been present among African people, but they been masked as Western knowledge. This illustrates that coloniality has made it difficult to correctly attribute knowledges to indigenous people (Ndlovu-Gatsheni, 2013). It is evident that elders in the villages of Limpopo possess knowledge about the health benefits of traditional food in relation to the mind and the body. These silenced narratives consequently affect knowledge production and economic trends relating to consumption (Maldonado-Torres, 2007). Godos et al. (2020) have argued that the prevalence and rapid increase of mental illnesses has compelled us to acknowledge the role of diet as a modifiable risk factor in the development of mental disorders. Participants of the present study critiqued the risks of Western and modernised food and pointed to the health benefits of traditional foods. These observations were based on their lived experience over many years of observing the dietary shifts that have occurred. Similarly, a study carried out by Jacka et al. (2017) found that a traditional diet consumed of whole grains, meat, fruits, fish, and vegetables were associated with a lower risk for the development of mental illness as compared to a Western dietary pattern. It is evident that traditional ways of eating are beneficial for one's well-being.

The study further explored common healing practices that are often utilized in the villages of Limpopo. It found that there are three healing systems currently used namely, indigenous, Western and an integrative healing system. It was evident that traditional and religious or spiritual modes of healing are predominately used. Indigenous healing systems include faith healers, herbalists, traditional healers etc. According to Swartz (1985), healing sought at churches and traditional healers are the two prevalent measures followed in South Africa. This is supported by Sehoana (2015) who found that indigenous healing systems are often approached first and hospitals which are identified as Western facilities are generally explored in later stages of illness. This was emphasized by some participants in this research who argued that they begin by observing if the person cannot be healed traditionally or religiously before seeking help at hospitals. Traditional and religious systems have been argued to be historically

aligned, cost-effective, familiar in the community and accessible in rural areas such as those found in Limpopo (Sorsdahl et al., 2009). A study done in Eastern Cape among Xhosa practitioners found similar results, emphasizing that healing is sought locally before community members approach hospitals and clinics (Lombo, 2010). Churches such as ZCC, popular in Limpopo province, were seen as important sites for the relief of mental illnesses (Mokgobi, 2012). Furthermore, traditional healing involves performing rituals and using herbs derived from natural ingredients such as shrubs and roots (Sodi, 2009). This healing practice is cosmologically and ecologically aligned to people's belief systems. It has defied colonialism and lasted across many generations. Its persistence may be understood as a decolonial practice.

However, participants also expressed their scepticism towards the indigenous healing systems of today. There has been a shift in how they trusted traditional healers in the past and the mistrust they have now in the present. These narratives are telling regarding how indigenous healing systems are perceived in the past, present and possibly the future. The participants' doubts questioned traditional healers' competency and intentions. There has been an ongoing dialogue of how to monitor the competency of indigenous healers (Zabow, 2007). Similarly, indigenous healers have been disrespected and not trusted by biomedical health practitioners (Hlabano, 2013). The contestations about traditional healing point to the insidious role of capitalism. In particular, participants often questioned the financial motives of healers.

Moreover, other participants emphasized the role of Western healing systems in managing the symptoms of mental illnesses. However, it has been argued that the introduction of Western mental health is progressing slow in most rural areas analogous to the ones where the present study was conducted. Thus, lack of understanding what services are offered is inevitable (Persent et al., 2009). However, participants in this study were knowledgeable of where to seek help and which hospitals or clinics to approach. There however seems to be an evident shift as there was some scepticism from some participants who argued that Western healing will not cure or heal a mentally ill person. Some believe that it could worsen their condition or at best it alleviates symptoms. This was echoed by studies conducted by Mbwayo et al. (2013) and Saravanan et al. (2008) where mental illness was believed to be caused by supernatural forces it was deemed to be incurable by Western healing systems. This coincides with critical African psychology that points to the contestations of knowledge between African and Western frameworks (Ratele, 2017). This is no surprise as scepticism towards Western modes of healing has been there for a long time and has been documented in many studies (Ross, 2008; Mkhize et al., 2004; Cooks, 2002; Mufumadi, 2001). Decolonial theorists argue that Western

approaches fail to understand a person in relation to their community, sociocultural context and cultural beliefs but instead chase after singular or universal meanings of illness and healing. However, this is problematic as societies, cultures, religions, communities, and broader contexts are not homogenous (Moletsane, 2005). This is important when we consider the perspectives of narrative and decolonial theories that seek to understand people in context.

Furthermore, it must be noted that some participants highlighted how both Western and Indigenous modes of healing are simultaneously used in their context. This signifies integration of the two healing systems. Meissner (2004) has argued that about 80% of the South African population follow the integrative approach of healing. This integrative approach aligns with Kleinman's (1977) holistic understanding of illness, which argues that if we integrate the two healing systems, we can have traditional medicine attending to the cultural concerns of the person and Western psychiatry responding to the disease problem. There have been multiple attempts to emphasize the need to reach a point where illness is understood holistically by considering both the biomedical and cultural perspectives (Sorsdahl et al., 2010; Petersen et al., 2009; Crawford & Lipsedge, 2004; Meissner, 2004). It is argued that today most of South Africans follow an integrative healing system that does not abandon the traditional forms of understanding illness that form an important part of their identity. However, it has been long unclear how professional spaces dominated by the Western-based mental health system would interface with indigenous healers (Pretorius & Moonsamy, 2020). Decolonial theory contends that modernity and its institutions and practices have always marginalised the other. Nwoye (2015) argues that to encourage decolonial thinking in Africa, Western and African conceptualisation of concepts such as mental illness and healing that have existed in pre-colonial and post-colonial era must be integrated so that they can co-exist without the one dominating the other. Thus, decolonising knowledge requires a decisive move towards plurality of "knowledges".

6.3 Conclusion

The discussion chapter shows that the findings found in this research echoes South African, African, and global literature. Following decolonial and narrative approaches, it has been shown that mental illness should be understood through multiple lenses, in context and through the promotion of plurality. The study discussed that the role of elders has always been significant and functioned as means for maintaining health and harmony in communities. Elders' experiences that they have accumulated through time ensures that knowledge about

health and other issues is kept intact and passed on intergenerationally. Literature also showed that what is considered madness in the communities found in Limpopo can be understood as psychosis in Western psychiatry. This manifests in the form of abnormal behaviours. The understandings and meanings of mental illness correlates with older literature on the genealogies of mental illness. Also, the study discussed how stigma in the communities that people are embedded in is based on how they make meaning of how the person became ill. However, the simultaneous practice of ubuntu challenges the stigma towards those who are mentally ill. Moreover, the literature coincided with the findings of the research regarding witchcraft, stress, substances, and food being causes of mental illness. This consequently affects how healing is sought. Most people utilise indigenous healing systems. Western and integrative healing systems towards mental illness were further discussed to the theoretical framework and existing literature. However, scepticism based on competence and effectiveness of both systems (indigenous and Western healing systems) was present. Ultimately, the discussion has demonstrated that holistic community wellness is at the heart of elders' conceptualisations and practices of healing.

CHAPTER 7: Strengths, limitations, recommendations and conclusion

7.1 Introduction

The final chapter of the research concludes the study. The limitations and strengths of the research are discussed. This is followed by the directions and recommendations for future research particularly relevant to the South African context. The last section of the chapter focuses on concluding the research.

7.2 Strengths and limitations

The narrative approach adopted by this study allowed the participants to express themselves fully. The use of semi-structured interviews enabled elders to tell their stories in a natural conversational flow while simultaneously ensuring that core aspects of the study are engaged. An important aspect of this study is that it engaged elders in their home language thus enabling them to freely express themselves. This addressed a significant gap in scholarship since most studies with the aged focus on English speaking populations. Various conceptions and understandings of mental illness are culturally rooted in the idioms of communities, and these might not be fully captured in the English vocabulary. As such, research conducted in participants' home language is able to provide rich and in-depth qualitative data as well as capture their lived experiences. Language plays an important role in narrative research and within the decolonial project. This is because it is the basis from which we come to understand people's experiences, lives, feelings, thoughts, and knowledge in an authentic manner. Additionally, the narrative approach of this study allowed elders to be storytellers who share knowledge about health and illness as understood in their villages. Elders tell great stories about the past, present and future. Moreover, even though gender representation was not an aim or objective of this study, this was achieved as half of the participants were men and half were women.

However, research is not immune to limitations that might be important to identify for future research. Participants that took part in the current study were from Greater Sekhukhune district. This means that there are other four districts in Limpopo that were not included in this research. This suggests that a holistic portrayal of all districts cannot be claimed by this study. However,

due to time constraints it was not possible to recruit participants from other districts. It is however possible that the findings of this study may be transferable to similar communities. It is important to stress that the interviews were conducted in Sepedi which means that the narratives of the older villagers in Limpopo have been translated into English. Translation serves two agendas in this study. It functioned as a strength and limitation. Firstly, translation might not fully capture the in-depth meaning and nuance of the narratives presented in the current research. However, translation allowed the knowledges, understandings and meanings older villagers have about mental illness to be transferable and heard by other people and the broader South African community, and perhaps beyond our context.

7.3 Recommendations

The first recommendation proposed by the current study following decolonial thinking is for scholars to conduct context-relevant research about mental illness to discover alternative truths and knowledges not only in South Africa or Africa but globally. This is because people make meaning of mental illness differently depending on context. Contextual issues should therefore not to be disregarded by researchers, policy makers and mental health practitioners. The study was limited to two villages in Limpopo with participants who predominantly spoke Sepedi. Hence, further exploration with other cultural groups speaking different languages is encouraged. This will add to the literature similar to that presented in this study. Moreover, to decentre single stories in our society we need to hear narratives of others. Thus, narrative studies are recommended as they enable us to hear stories about the past, present and future which is central in knowledge production. It is important for researchers and health practitioners to start acknowledging that people analogous to the ones who participated in the study might make meaning of mental illness differently from Western conceptions of mental illness. However, that does not mean that they are illiterate about mental illness and health. Rather, they understand and make meaning of mental illness through different lenses. Lastly, research that could present direct quotations of the language spoken by the participants in addition to translated excerpts, could be beneficial in conveying in-depth meanings in their raw form to readers who could otherwise understand the language spoken by the participants. This would allow them to directly access the data and to make their own interpretations.

7.4 Conclusion

The study explored the narratives about mental illness among older villagers in Limpopo. Mental illnesses are currently a public concern due to their increasing prevalence globally and

South Africa and villages in Limpopo are not an exception to this. It has been highlighted that more studies need to be conducted as means to explore how diverse populations and communities make sense of mental illness. As an attempt to also ensure that mental health services are context relevant and culturally sensitive.

Furthermore, it was found that elders in the villages of Limpopo play important roles that impact how health is maintained. While these roles vary from one elder to another, they all contribute significantly to how health and mental illness is managed in their communities. Furthermore, it was found that madness is a common label that is used to describe mental illness which is manifested in the form of abnormal behaviours such as hallucinations, wandering on the streets naked etc. The study further revealed that stigma towards the person who is mentally ill is dependent on how the community make sense of what caused the illness. In most instances, it was found that witchcraft rooted in envy/jealousy was deemed to be the main cause of mental illness. This was followed by stress, food, and substances. Moreover, healing was predominantly found to be sought from indigenous healers first (traditional and religious). However, some participants highlighted the use of Western healing systems. The mentioned healing systems both received criticism from the participants. Moreover, other participants emphasized the importance of integrating the two or using them simultaneously to tackle mental illness.

These findings reveal that local people carry knowledge(s) that might or not be analogous to the Western model of mental illness. Thus, rather than dismissing local narratives about mental illness, the mental health field would benefit significantly from this body of knowledge to enrich and extend on the existing knowledge and literature. This not only functions as means to carry out the decolonial project in the South African context but ensures that people's voices and narratives are not silenced but heard.

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APPENDICES

APPENDIX A1: INFORMATION SHEET

Greetings Sir/Madam,

My name is Mohlale Sunday Paledi and I am a Masters student in Community-Based Counselling Psychology at the University of the Witwatersrand, Johannesburg. As part of my studies, I have to undertake a research project. The project explores the narrative accounts of mental illness by older villagers in Limpopo. The research is supervised by Professor Hugo Canham. The aim of this research project is to explore and understand meanings, knowledges, and various healing systems of mental illness from the perspective of the narratives of older villagers.

As part of this project, I would like to invite you to take part in an interview which will involve telling stories about mental illness and will take about 60-90 minutes. With your permission, I would also like to record the interview using an audio recorder. Participation will not involve personal costs to you. You will not receive any direct benefits from participation but there are no disadvantages or penalties if you choose not to participate. You may withdraw at any time and you may choose not to answer particular questions. If you experience any distress or discomfort at any point in this process, we will stop the interview or resume at another time. The interview will be confidential, and data will be safely stored in a password protected computer. Only my supervisor and I will have access to the interview data. I will maintain anonymity by removing identifying information from the data. I will write up the data using a pseudonym (false name) to ensure that you are unidentifiable.

If you have any questions about this research, feel free to contact me on the details listed below. This study will be written up as a research report which will be available online through the university library website. If you wish to receive a summary of this report, I will be happy to send it to you. If you have any concerns or complaints regarding the ethical procedures of this study, you are welcome to contact the University Human Research Ethics Committee , telephone +27(0) 11 717 1408, email hrec-medical.researchoffice@wits.ac.za.Your participation in this study will be greatly appreciated.

Yours sincerely,

Mohlale Sunday Paledi.

Email: 1423286@students.wits.ac.za. Phone number: 0825123286

Supervisor:

Professor Hugo Canham.

Email: hugo.canham@wits.ac.za

APPENDIX A2: TRANSLATED INFORMATION SHEET

MAMETLETŠO YA A: LATLAKALA LA TSHEDIMOŠO

Thobela Morena/Mohumagadi

Leina laka ke Mohlale Sunday Paledi ebile ke ithutela tikrii ya Community Based-Counselling Psychology kua Yunibesithi ya Witwatersrand, Johannesburg. Bjale ka dinyakwa tša dithuto tšaka ke swanetše gore ke dire dinyakišišo. Ke hlahloba dikanegelo tša malwetši a monagano tša bagolo ba mo motseng wa bo lena mo profenseng ya Limpopo ka tlase ga Molaodi waka, Mohlomphegi Hugo Canham. Maikemišetšo goba morero wa dinyakišišo tše kego hlahloba lego kwešiša ditlhalošo, ditsebo le ditsela tše dingwe tšeo di fodišago malwetši a monagano gotšwa go dikanegelo tša bagolo ba motseng wa Limpopo.

Bjale ka karolo ya dinyakišišo ye nka rata gole laletša go tsenela dipoledišano tšeo ditlogo amagaganya le go bolela ka dikanegelo tša malwetši a monagano ebile dipoledišano tšona ditlo tšea metsotso ye eka bago go thoma go masometshela go iša go masomesenyane. Ka tumelo ya gago, nka rata go e bega mo rekoteng ya dikgatišo tša go theetšwa. Go tšea karolo mo dinyakišišong tša rena go kase beye bophelo bja gago kotsing le gona geo tšea karolo ago tloba le ditefo. Ge ele gore o kgetha go ikgogela morago mo dinyakišišong tša rena goka se be le dikotlo tše di latelago. Oka ikgogela morago mo dinyakišišong tša rena nako e nngwe le e nngwe yeo o nyakago ka gona. Gape, oka kgetha go se fetole dipotšišo tša poledišano. Ge ele gore okwa go se iketle goba maikutlo a mmele ase gabotse oka emiša dipoledišano gore re tswele pele nako e nngwe. Poledišano e ke sephiri ka bjalo maina a gago atlo utwa gore ose

tsebagale ka ge ketlo diriša maina a boikgopolelo go emela mantšu a gago geke ngwala dinyakišišo tšaka mafelelong. Rekota ya dipoledišano tša rena etlo beiwa ka gare ga khomphutha yeo e šereleditšwego ka dinomoro tša sephiri tšeo di tšebjago ke nna fela, eupša etlo theelwetšwa ke nna le molaodi waka, Mohlomphegi Hugo Canham.

Ga eba onale dipotšišo ka dinyakišišo tše, o ikwe o lokologile o ikgokaganye le nna ka dinomoro le aterese yeo e filwego ka fase. Thuto ye etlo begwa bjalo ka dinyakišišo gomme ya hwetšagala inthaneteng ya bokgobapukung ka Yunibesithi. Ga ele gore o ka rata kakaretšo ya letlakala la dinyakišišo nka thaba go romela yona. Ga ele gore onale dipelaelo goba ditshwenyego mabapi le maitshwaro a dinyakišišo tša rena o lokologile goka ikgokaganya le komiti ya maitshwaro a mabotse a dinyakišišo Yunibesithing ya Witwatersrand, dinomoro tša bona ke +27(0) 11 717 1408 ga mmogo le e-poso ke hrec-medical.researchoffice@wits.ac.za. Karolo ya gago mo dinyakišišong tše e tla lebogwa kudu.

Ka kgopela le boikokobetšo

Mohlale Paledi

Monyakišišo

Mohlale Sunday Paledi.

E-Pošo: 1423286@students.wits.ac.za.

Dinomoro tša mogala: 0825123286

Molaodi

Mohlomphegi: Moporofesara Hugo Canham.

E-Poso: hugo.canham@wits.ac.za

APPENDIX B1: PARTICIPANT CONSENT FORM FOR INTERVIEW

I, _____, consent to being interviewed by Mohlale Paledi, for her study exploring the narratives of mental illness by older villagers in Limpopo.

Please tick relevant boxes. I understand that:

- Participation in this study is voluntary. ☐

- I may refrain from answering any questions. ☐

- I may withdraw my participation and/or my responses from the study at any time before the research report is examined. ☐

- There are no risks or benefits associated with participation in this study. ☐

- All information provided will remain confidential, although I may be quoted in the research report. ☐

-If I am quoted, a pseudonym (Participant A, Respondent B etc.) will be used. ☐

- None of my identifiable information will be included in the research report. ☐

- I am aware that the results of the study will be communicated in the form of a research report or journal articles. ☐

- The research may also be presented at a local/international conference and published in a journal and/or book chapter. ☐

Signed: _____

Date: _____

TRANSLATED APPENDIX B2: PARTICIPANT CONSENT FORM FOR INTERVIEW

MAMETLETŠO YA B: FOROMO YA TUMELO KA POLEDIŠANO

Nna, _____, ke dumela go tsenela poledišano le Mohlale Sunday Paledi, mabapi le dinyakišišo tša dikanegelo tša bagolo ba motseng wa Limpopo ka malwetši a monagano.

Kgopela o dikologe kgetho yeo o dumelelanago le yona go tšeo di latelago. Ke kwešiša gore:

- Ke tsenela poledišano ya dinyakišišo tše ka boithatelo, go tšea karolo mo dinyakišišo tše a se gapeletšo. ☐

- Nka ikgogela morago go fetola dipotšišo ☐

- Nka ikgogela morago mo dinyakišišong tše ka nako ye nngwe le ye nngwe, ekaba pele goba magareng ga poledišano ya dinyakišišo, pele dinyakišišo di phatlalatšwa, ntle le dikotlo. ☐

- Gaka letela go hwetša tefo goba go lefswa ka tšhelete ga mmogo leka mekgwa ye mengwe ya tefo go tsenela poledišano ya dinyakišišo. Le gona a gona dikotsi go tsenela dinyakišišo tše. ☐

- Ke dumela gore monyakišišo aka šomiša ditsopolwa tšaka ka ntle le go utulla maina aka ☐

-Kea kwešiša gore seina saka setlo fihlwa ge poledišano ya dinyakišišo e ngwadiwa mafelelong (Mohlala; Motšea-karolo A or B). ☐

- Dikagare le ditsopolwa tša poledišano ya dinyakišišo tšeo ditlo kgatišwago phatlalatša dikase bolelwe ka maina gore ditšwa go mang gomme maina aka a tloba sephiri. ☐

- Poledišano ya dinyakišišo e tlo gatišwa ka rekota go tloga moo poledišano e tla ngwadiwa fase letlakaleng. Ke a tseba gore dinyakišišo tše ditlo kgatišwago phatlalatša. ☐

- Monyakišišo aka tšweletša goba a kgatiša poledišano ya rena ka gare ga dipukwana tša ditšahaba-tšhaba. ☐

Mosaeno wa motsenyaletsogo/motšea-karolo_____

Letšatši_____

APPENDIX C1: RECORDING AND QUOTATION CONSENT FORM

I, _____ give my consent for my interview with Mohlale Paledi, to be audio recorded for their study. Please tick the relevant boxes.

I understand that:

- The audio-recordings and transcripts will not be seen or heard by anyone other than the researchers and/or their research assistants. ☐

- The audio-recordings and transcripts will be kept in a password protected computer. ☐

- No identifying information will be used in the transcripts or the research report. ☐

- Although direct quotes from my interview may be used in the research report, I will be referred to by a pseudonym. ☐

Signed:_____

Date:_____

TRANSLATED APPENDIX C2: RECORDING AND QUOTATION CONSENT FORM

MAMETLETŠO YA C: FOROMO YA DIKGATIŠO TŠA GO THEETŠWA

Nna, _____ ke dumela go tšea karolo mo dinyakišišong tša Mohlale Sunday Paledi, ke fa tumelo yaka mabapi le gore poledišano ya rena eka rekotwa ka mokgwa wa dikgatišo tša go theetšwa.

Kgopela o dikologe kgetho yeo o dumelelanago le yona go tšeo di latelago. Ke kwešiša gore:

- Rekote ya dinyakišišo etlo theetšwa ke monyakišišo le molaodi wa gage goba bathuši ba molaodi fela. ☐

- Rekote ya dinyakišišo tša go theetšwa e tlo bolokwa ka lefelong leo le bolokegilego elego khomphutha, ka dinomoro tša sephiri tšeo di tsebjago ke monyakišišo. ☐

- Maina aka a tloba sephiri ge poledišano e ngwadiwa fase letlakaleng. ☐

- Le ge ele gore dikagare le ditsopolwa tša poledišano ya dinyakišišo di ka šomišwa goba tša kgatišwa, seina saka setlo fihlwa (Mohlala; Motšea-karolo A or B). ☐

Mosaeno wa motsenyaletsogo/motšea-karolo_____

Letšatši_____

APPENDIX D1: INTERVIEW GUIDE

I would like to thank you for agreeing to participate in my study. Before beginning with the interview, I would like to assure you that everything you say during this interview will be kept confidential. Before beginning the interview, I will need you to read through and sign these two consent forms (See Appendix A and B).

Thank you. If you are ready, we can begin the interview.

QUESTIONS

The following are the three broad questions that will be asked:

1. What has been your role in the society especially in this village, historically and currently and how have they changed or remained the same as you are an elder now?
2. As an elder in this village, what are the historical understandings, causes and meanings of mental illness and have they changed or stayed the same with time?
3. What are the known healings systems and challenges for healing mental illness? Have they changed or remained the same till to this day?

However, additional questions that may be asked as to follow up questions that underpin the preceding three, are as follows.

4. Please share your earliest memories of hearing about mental illness

5. Has your understanding of mental illness changed over time? If so, how?
6. What might have influenced how you think about mental illness?
7. Have you known anyone with a mental illness? Tell me about your views of this person?
8. What do you think causes mental illness?
9. Do you think that other people from this village share your understandings of mental illness, or do you think your views are different? If they are different, how are they different.
10. What do most people from hear think about mental illness?
11. Tell me about how you think mental illness can be treated?
12. What do you know about how traditional healers deal with mental illness?
13. Tell me your thoughts about how hospitals and clinics treat mental illness?

TRANSLATED APPENDIX D2: INTERVIEW GUIDE

MAMETLETŠO YA D: LENANEO LA POLEDIŠANO

Hlogo ya dinyakišišo: Dikanegelo tša bagolo ba motseng wa Limpopo ka malwetši a monagano.

Ke rata go le leboga ge le dumetše go tšea karolo mo dinyakišišong tšaka. Pele re thoma ka poledišano ya rena, ke rata go le kgonthišiša gore sengwe le sengwe se o se bolelago mo poledišanong ya rena e tloba sephiri. Pele re thoma poledišano, ke hloka gore o bale gape o saene diforomo tša ditumello tše pedi elego mametletšo ya A le B.

Kea leboga, ge le lokile reka thoma poledišano

Dipotšišo
Tše di latelago ke dipotšišo tše tharo tšeo ditlo botšišwago:

1. Ka ge ole mogolo mo motseng o, ke efe karolo yeo o e bapalago mo šetšhabeng kudu-kudu mo motseng o dulago gona, ge nako entše e tšwela pele, o bona karolo ya gago e fetogile goba e sa swana le kgale/peleng?

2. Bjale ka mogolo wa motseng o, ke eng ditlhalošo le dibaki (dilo tšeo di hlolago/bakago malwetši a monagano) tša malwetši a monagano go ya ka thlaloganyago ya lena le gona di fetogile ge nako entše e tšwela pele goba di sa swana le tša kgale?
3. Ke di fe ditshepidišo tša go fodiša malwetši a monagano tšeo di kgethwago kudu-kudu go ya ka go tsebja ga tšona le gona ke mathata a mehuta mang a lego gona ge le leka go fodiša malwetši a monagano? di fetogile ge nako entše e tšwela pele goba di sa swana le tša kgale?

Empa, dipotšišo tše di latelago di ka oketšwa godimo ga tše tharo tšeo di botšišitšwego go matlafatsa poledišano, tšona di latela ka tsela e:

4. Kgopela o hlalose megopoolo ya gago ya gauswana ka go kwa ka malwetši a monagano.
5. E ka ba kwešišo ya lena ka malwetši a monagano e fetogile ge nako entše e tšwela pele? Ge ele gore go bjale, e fetogile bjang?
6. Ke eng seo se hlohloletšago ka mokgwa o le naganago ka malwetši a monagano?
7. Le sale la tseba motho o a nalego bolwetši bja monagano? Kgopela le mpotše ka mokgwa o le mo bonago goba lebelelago ka gona?
8. Le nagana gore malwetši a monagano a hlola/baka ke eng?
9. Le nagana gore batho ba bangwe mo motseng wa bo lena ba kwešiša malwetši a monagano go swana le wena goba o nagana gore ka mokgwa le kwešišago malwetši a monagano gwa fapana? Ge ele gore gwa fapana, go fapana bjang?
10. Batho ba bangwe ba go tšwa mo motseng wa bo lena ba nagana bjang ka malwetši a monagano?
11. Kgopela le mpotšeng gore le nagana gore malwetši a monagano aka fodiša ke eng?
12. Le tseba ka mokgwa o dingaka tša setšo di kgonago go alafa malwetši a monagano?
13. Kgopela o mpotše dikgopolo tša gago ka di dipetlele le dikliniki tšeo di alafago malwetši a monagano.

APPENDIX E: ETHICS CLEARANCE CERTIFICATE

SCHOOL OF HUMAN AND COMMUNITY DEVELOPMENT ETHICS COMMITTEE
CONSTITUTED UNDER THE UNIVERSITY HUMAN RESEARCH ETHICS COMMITTEE (NON-MEDICAL)

CLEARANCE CERTIFICATE: PROTOCOL NUMBER: MACC/20/010

PROJECT TITLE: Narrative Accounts of Mental Illness by Older Villagers in Limpopo.

INVESTIGATOR Paledi Mohlale (1423286)

SCHOOL/DEPARTMENT OF INVESTIGATOR SHCD/Psychology

DATE CONSIDERED	15 May 2020
DECISION OF THE COMMITTEE	Approved unconditionally
RISK LEVEL	Low Risk
EXPIRY DATE	31 December 2022

ISSUE DATE OF CERTIFICATE 21 May 2020

CHAIRPERSON

(Dr Vinitha Jithoo)

cc: Prof. Hugo Canham (Supervisor)

DECLARATION OF INVESTIGATOR

To be completed in duplicate and **ONE COPY** returned to the Chairperson of the School/Department ethics committee.

I fully understand the conditions under which I am are authorized to carry out the abovementioned research and I guarantee to ensure compliance with these conditions. Should any departure to be contemplated from the research procedure as approved I/we undertake to resubmit the protocol to the Committee.

MS Paledi

Signature **Date** **16/05/2020**