AN EXPLORATIVE STUDY INTO FAITH HEALING AS AN AFRICAN BELIEF SYSTEM AND ITS INFLUENCE ON THE DIAGNOSIS AND TREATMENT OF MENTAL ILLNESS IN THE EASTERN CAPE PROVINCE, SOUTH AFRICA.

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Abstract

The present study specifically focussed on Faith healing as an indigenous healing system and its influence on the diagnosis and treatment of mental illnesses in the Eastern Cape province of South Africa. The study aimed to provide a descriptive overview of Faith healers' perspectives on the diagnosis and treatment of mental illnesses in the Eastern Cape, as well as to compare conclusions reached with other categories of indigenous healers. The inter-category comparisons on a broader level allowed for a further comparative discourse with the mainstream western medical psychiatric view of mental illness. Therefore, the scope of this study does not include in-depth analyses of findings, but rather the generation of themes for comparative discussions. While there exists vast literature on the diagnostic and treatment perspectives of the other two categories of indigenous healing systems (traditional healers and herbalists), a limited number of studies have been focussed on Faith healing as an indigenous mode of healing. The present study attempted to address this gap in the literature in an effort to promote future collaborative work across all viewpoints, in the management of mental illnesses. This study, grounded in qualitative research, utilized thematic analysis as its theoretical framework. Non probability judgmental sampling was used to secure self-identifying Faith healers, where conclusions from them were drawn from data collected, using in depth semi-structured interviews and observation. The main findings of the study indicated that Faith healers' perspectives on the diagnosis and treatment of mental illnesses are based mainly on indigenous cultural theories. Furthermore, that collaboration with other viewpoints is hampered by animosity, feelings of distrust and the fear of appearing inferior.

Keywords: Faith Healing, Diagnosis, Treatment, Mental Illness, Thematic Framework, Indigenous Theories

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Chapter 1: Introduction and Statement of the Problem

1.0. Introduction

The following chapter puts focus on the initial grounding of the study in literature. It covers the initial stages which caused the researcher to embark on this study. Its function is to highlight critical issues such as the statement of the problem, the rationale of the study, the aim and objectives of the study and lastly, the structure of the rest of the study.

1.1. Statement of the Problem

This study's main concern is, how Faith healers as a category of indigenous healers, account for their diagnosis and treatment of Mental illnesses

In 2013, mental illness attributed to 14 per cent of the global burden of diseases and 75 per cent of those affected by its broad diagnosis spectrum (such as anxiety, substance abuse and psychosis) are found in low-income countries (Amuyunzu-nyamongo, 2013). The South African Stress and Health Study conducted between 2002 and 2004 as noted by Sorsdahl, Stein, Grimsrud, Seedat, Flisher, Williams and Myer (2011) found that at least 30% of adults have experienced a DSM- IV disorder in their lifetime (with anxiety disorders accounting for 16% of the mental illness, mood disorders accounted for 10% and 13% of the adults reported having had substance used in disorder). Furthermore, South Africa has a higher prevalence of mental illnesses than many low-middle income countries. The survey conducted in the years indicates that nearly one in three South Africans will suffer from a mental disorder in his or her lifetime.(Jack, Wagner, Petersen, Thom, Newton, Stein, Khan, Tollman & Hofman, 2014).

Amuyunzu-nyamongo (2013) notes that, the definition of the nature, causes and interventions of mental illness/health is socially constructed depending on diverse societies, groups, cultures, institutions and professions. Such definition rests on the field of psychology which has its roots deeply entrenched in Western ideology of understanding behaviour and mental illness, and is still relatively new to large population groups in South Africa, especially black populations in rural areas (Cooper & Nicholas, 2012).

The Western Ideology is defined by Kontos, Freudenreich and Querques (2006) as a system based mainly on biomedical explanatory models of mental illness. The biomedical model of

the Western Ideology as noted by Kaplan and Sadock (2007) maintains that all illnesses can be explained on the basis of aberrant somatic processes. The bio-psychosocial model is defined as an explanatory model that operates on three main spheres namely; Biological, Psychological and Social (Ghaemi, 2009). The definition of the biological model given by Kaplan and Sadock (2007) implies that mental illness can be traced through scientific enquiry to disordered cells within the person while the bio psychosocial model provides a different approach stating that all healthcare tasks should take into consideration the three spheres and that no patient or illness can be simply reduced to cellular levels. The same can be said of mental illness (Ghaemi, 2009). Saxena, Thornicroft, Knapp and Whiteford (2007) further indicate that proponents of the western orientated approach to mental health services is mainly made up of Psychiatrists, Psychologists, Psychiatric nurses and Social workers.

It is therefore important that one defines "Western orientated approach" clearly and operationally for the purposes of this study. Throughout this study, reference to a health worker will refer to the Western Medical Psychiatric Orientation to which the majority of Clinical Psychologists and Psychiatrist subscribe.

The definition of natural causes and treatment of mental illness can also be socially and culturally constructed. For instance, in his distinction between traditional and modern methods of understanding and treating mental illness, Edwards (1986) argues that traditional healing systems are more culturally relativistic, humoral and functionally strong compared to modern orientations. Furthermore, Campbell-Hall, Petersen, Bhana, Mjadu, Hosegood and Flisher (2010) maintain that this treatment method is the one that is culturally relevant to African traditional people as it is driven by indigenous explanatory models which are culturally ingrained in people. Thus, these models inform their interpretations of their illnesses in relation to the causation, precipitating events, and symptomology. These models also influence treatment options (including the utilisation of Traditional and Spiritual healers). Furthermore, in societies where African people are the dominating race, there are far more traditional healers than Western Trained Mental Health Professionals. Replacing them is therefore almost impossible (Campbell-Hall et al., 2010).

The cultural definition of mental illness is prominent on the African continent. Mental illness is a taboo subject in many of these societies. It attracts stigma which can be attributed to lack

of education, fear, religious reasoning and general prejudice (Amuyunzu-nyamongo, 2013). Social stigma has meant that in much of Africa, mental illness is a hidden issue equated to a silent epidemic. Furthermore, the financial burden on families, lack of human resources and lack of accessible treatment facilities in most African countries has contributed to the inadequacy of addressing the burden of mental health disorders (Amuyunzu-nyamongo, 2013).

Amuyunzu-nyamongo (2013) further argues that indigenous healers provide a significant proportion of the care received by the mentally ill. Mentally ill individuals are usually shown more empathy by their communities if they visit an indigenous healer than if they choose to seek help from a mental hospital. Ross (2010)indicates that the spectrum of indigenous healers includes Diviners (who have a link between humans and the supernatural being whose healing is divine, and usually diagnose illnesses by consulting the ancestors through throwing bones, cards or stones), Herbalists (who are able to diagnose and prescribe herbal treatments and enemas for a range of ailments and are expected to be able to provide protection against witchcraft, to prevent misfortune, and bring prosperity and happiness) and Faith healers or prophets (who also have a link between human and the supernatural being and whose healing is divined within the framework of African Independent Churches).

While the diagnosis and treatment process of indigenous healers is centred on the patient's experiences. Kontos, Freudenreich and Querques (2006) noted the health worker to have a tendency of disregarding the patient's experiences by insisting on the western way of explaining symptoms presentation. This has resulted in more reliance on indigenous healing systems in African societies as they appear to be more culturally relevant.

1.2. Rationale for the study

The motivation for this study rests on three main aspects namely, the expansion of the Faith healing movement in South Africa, the concurrent usage of both the western orientated and indigenous health care systems by patients and the media scrutiny placed on Faith healing.

Pfeiffer (2005) reports that the extraordinary expansion African Independent Churches in South Africa, which founded the Faith healing movement, has seen a dramatic shift away from reliance on "traditional healers" in the treating of persistent afflictions believed to have

spiritual causes. There are now more practising Faith healers, especially in rural areas, so the need to understand the nature in which they work has become an important aspect. Ross (2010) adds to this reporting of a South African context where 80% of health service users use both systems concurrently, by further emphasising the need for collaboration between the two especially with regards to the treatment of severe mental illnesses where adherence from a biological perspective is paramount. However, even though Campbell-Hall et al. (2010) noted that involving indigenous healers in the care of common mental issues can help narrow the treatment gap of these problems in the country, the un- encoded nature of indigenous healing systems has come under great scrutiny. Numerous newspaper articles (Claassen 2016; Gorton 2014; Madibane, 2015) argue the sustainability, relevance and purity of Faith healing practices, thus intensifying the need for such a study.

1.3. Aim of the Study

This study is aimed at exploring the influence faith healing has an African belief on the diagnosis and treatment of mental health illnesses in the Eastern Cape Province of South African. The purpose of this aim is to fill the gap in existing literature about the diagnostic and treatment perspectives of Faith healers, in their treatment of mental illnesses.

1.4. Specific Research Questions

The aim of this study been achieved by collecting information through a chosen research design and methodology explained in latter chapters (Chapter 3), to answer the following specific research questions:

1. How do self-identified faith healers describe their training and preparation to become faith healers?
2. How do self-identified faith healers view presentations of mental illness?
3. How do self-identified faith healers understand the causes of mental illness?
4. How do self-identified faith healers understand the treatment options of mental illness?
5. How do self-identified faith healers collaborate with the medical model of understanding mental illness?

1.5. Structure of the study

- Chapter 2

This chapter explores the available literature surrounding indigenous healing. It is divided into four themes, where the first theme presents the nature and training of indigenous healers, the second theme discusses the perspectives of indigenous healers in the diagnosis of mental illness, the third theme explores the treatment procedures employed by indigenous healers and the fourth and last theme deliberates on the interrelationship of indigenous healers and Western Psychiatry.

- Chapter 3

This chapter presents the research design and methodology utilized in the collection and analysis of data. The chapter is divided into three broad sections; the first section identifies the Research Design of the study, which consists of the study area, the target population, sampling procedures and the duration of the study. The second section presents the Research Methodology and the research techniques employed in the study. Thirdly, before concluding, the ethical considerations including the validity and reliability principles of the study are presented.

- Chapter 4

This chapter presents the results and discussion of the data collected from the chosen sample group. Here all raw data is analysed using a thematic framework (see Braun & Clark, 2006), where the dominant and sub-dominant themes observed from the data are explored. Their presentation has been followed by a critical discussion relating them to the literature reviewed in previous chapters, as well as showing contradictions observed in literature.

- Chapter 5

This chapter provides concluding remarks on the outcomes of the study, while highlighting areas for possible future studies. Included in this chapter is the researcher's concluding subjective experience of the process.

Chapter 2: Literature Review

2.0. Introduction

This chapter reviews the literature that explores traditional faith healing with regards to its diagnostic and treatment process of mental illness. The chapter is divided into four themes, where the first theme presents **the nature and training of indigenous healers**, the second theme discusses **the perspectives of indigenous healers in the diagnosis of mental illness**, the third theme explores **the treatment procedures employed by indigenous healers** and last theme deliberates **the interrelationship of indigenous healers and Western Psychiatry**.

2.1. Nature and Training Duration of Indigenous Healers

Saxena et al., (2007) indicate that proponents of a Western orientated approach to mental health services is mainly made up of Psychiatrists, Psychologists, Psychiatric nurses and Social Worker. Vontress (1991) however reports that, many Africans believe in a vital force that directs everything in the universe and that the few individuals who have acquired the skill to manipulate this force are regarded as indigenous healing specialists, with the ability to combat physical and mental illnesses.

Makhanya (2012) notes that, indigenous healers have three broad categories namely: **diviners** (who are believed to be chosen by their ancestors), **herbalists** (who individually chose to embark on the journey to study traditional herbs) and **faith healers** (who are guided by their Christianity). Furthermore, Ross (2010) indicates that, African traditional healers acquire their skills through apprenticeship from an older healer whereby the calling or spiritual emergence is translated to the new healer through the transference of certain techniques or conditions which the older healer possesses. Edwards et al., (1983) reiterates this view stating that, illnesses viewed to be of supernatural causation are assessed by one of the three broad categories of indigenous healers (a Diviner/**isangoma**, an Ethno doctor/**inyanga** and the focus of this study namely; the Faith healer/**umthandazeli**), depending on the patient's choice of whom to consult.

Ross (2010) noted that Diviners identify their calling through many forms, which can include a dream, a vision or a feeling. Other times the calling is believed to make them sick so they

can consult an already established traditional healer in which case their diagnosis would be that they have been "called" by the ancestors and therefore must go through the process of initiation known as "ukuthwasa" *(derived from the isiXhosa concept of Thwasa meaning 'the emergence of something new')* in IsiXhosa, and if the calling is ignored that individual remains sick or suffers ill fortune until they accept it (Ross, 2010).

Herbalists, who also form part of traditional healers, are ordinary people who do not possess supernatural powers but have acquired extensive knowledge of herbal treatments. These individuals are able to diagnose illnesses and prescribe herbs that they believe will aid incurring the illnesses or in protecting individual clients or families against evil spirits (Ross, 2010).

A faith healer according to Makhanya (2012) is often a professed Christian who either belongs to the mission or African independent churches, and who believes that their healing power comes from the "Almighty" through euphoric states and trance contact with a spirit or combination of the Christian Holy spirit and the spirit of the ancestors.

Mzimkhulu and Simbayi (2006) provide the following extended account of the training of the three different categories of indigenous healers to that offered by Makhanya (2012) and Ross (2010):

- Traditional healer or Diviner/**Isangoma or Igqirha**

The training of a Diviner begins with a calling or a state of apprehension known as "ukutwasa", which takes place in the form of a dream involving an ancestor who informs the individual that the ancestral shades wish to utilize them by bestowing them with the gift of healing. By accepting the calling, the individual moves from a neophyte via apprenticeship to a seasoned diviner, learning how to enter the spirit world and becomes blessed with clairvoyant powers to divine, the training process can take up to several years where the individuals' power is said to be revealed in dreams through "uchazo lwethongo" or dream interpretation, during diviner rituals such as the ritual dance known as the "Ukuxhentsa" and a form of group therapy known as "Intlombhe"

- Ethno doctor or Herbalist/ **Inyanga**

The Herbalist' training is somewhat similar to that of Western trained doctors as the individual embarks on it by choice and not by an ancestral calling. The individual is trained for a period of time (several years) by a recognised Herbalist to recognise, mix and use herbs to heal. Herbalists are seen as a first line of defence as Africans have a long history of using plants for every condition that ails them (Vontress, 1991).

- Faith or Spiritual healer/ **Umthandazeli** (the focus of the study)

The Faith healer is called and trained in a similar manner as a Diviner, as stated earlier, this is seen as a direct result of the rise of the African Independent Churches, which are not traditional in the true sense of the word, in that they did not exist before the development of western medicine. Faith healers share a common theory of health and disease with other indigenous healers; divine in a similar manner and; treat various diseases with herbs and medicine.

Even though power to heal is viewed as a gift or calling, it must be cultivated through intense training and supervision where the duration of training varies depending on the intelligence and deposition of the student to learn (Vontress, 1991). Even though there is no stipulated duration of training, it has been known to take many years with the average being a period of 9 years and one can only be seen to have mastery of their specific category of healing only after getting thorough understanding of following nine aspects of training as according to Vontress (1991, p. 247):

1. *Medicinal value quality and use of herbs,*
2. *The causes, cures and prevention of illnesses,*
3. *Magic, witchcraft and how to combat it,*
4. *Techniques for communicating with the spirits,*
5. *Various trade secrets of Indigenous traditional healing,*
6. *A vast body of literature, mythology and associated rituals,*
7. *Specific healing techniques and the language of healing,*
8. *Interview techniques and*
9. *Methods of divination,*

The training period for faith healers is not planned since as part of training the student is prayed for and is subjected to purification rites which enable close contact with the healer (Makhanya, 2012) Differences between the diviners and faith healers may rest in the

treatment procedures they employ to certain illnesses among their clients. However, there are similarities that can be observed between the two indigenous healers' diagnosis and treatment procedures as they both require the consultation of the ancestors or spirits for guidance (Schoffeleers, 1991).

Bate (2001) in support of this view state that within the African independent church movement, the faith healer has emerged as an indigenous healer through borrowing heavily from the traditional healer in African tradition. Furthermore, the extraordinary expansion of the faith healing movements has seen a dramatic shift away from reliance on "traditional healers" in the treating of persistent afflictions believed to have spiritual causes (Pfeiffer, 2005). This has now led to the argued notion that faith healing, has taken many of the roles of the Diviner as its own leading to animosity between the two modes of healing with each claiming to be a better mode of healing than the other (Edwards et al., 1983). The diminished reliance on traditional healers for treatment has been attributed by Pfeiffer (2005) to the increase in their consultation fees as well as the confusion concerning the overlap between witchcraft, sorcery and traditional healing techniques. Given the nature of their skills, traditional healers are able to harness both good and evil from the spirit world in order to heal, cure, bring misfortune or kill, and this has led to their healing practise to be viewed with a degree of ambivalence by prospective "patients" (Pfeiffer, 2005).

Schoffeleers (1991) states that, although healing churches are also active in other Sub-Saharan countries, nowhere are they as numerous as in the Republic of South Africa. This further seen to be a result of contrasting beliefs from their more Western counterparts relating to the power of witchcraft, evil spirits or other mystical objects. This climate for dissent also resulted from the occupation of tribal lands by Europeans; the missionary churches unsympathetic approach in the attack of indigenous belief systems; as well as the failure to apply the biblical concept of love through treating tribal people with respect (Daneel, 1970). Thus independent Healing Churches are seen by their Western missionary church counter parts as political protest movements against the background of African Nationalism and Colonial paternalism (Daneel, 1983).

Pfeiffer (2005) reiterates the above statements indicating that, social inequalities over the past decades have led to perceived spiritual threats to health in an environment characterized

by conflict, and have driven the popularity of these churches among Africans. Instead of refuting indigenous beliefs systems (as done by missionary churches), these churches thrived because they operate within the parameters of acculturation between African tradition, Black working class culture and traditional Christianity (Bate, 2001).

Daneel (1983) weighing in on this debate noted that even though these churches have in the past been seen by missionary scholars as "sheep stealers" who thrive on the membership of missionary church defectors; there exists a school of thought that views "Independency" as a direct reaction to missionary failures. Furthermore, Anderson (1991) makes note of 2 main missionary failures that led to the thriving "Independency" namely: the view that the Holy Spirit has simply replaced the function of the ancestors and Western Theology's Dichotomous (body and soul) biblical view of humankind.

Missionary churches' failure to accept the indigenous view of humankind (holistic) characterized by the interaction of both the physical and spiritual world, and the existence of ancestors led to the formation of "Africanized" independent churches (Anderson, 1991). Furthermore, the main draw point of these independent churches is that they allow members to be Christian and African at the same time (Meyer, 2004).

The above view has been further emphasised by Bate (2001) who noted that, the 1999 South African census showed about 45% of Christians in south Africa belonged to churches which focus on healing and 51% of the that group are Black. Additionally, Daneel (1983) reported that during 1940-1960 the membership of independent churches rose from 9.6% to 20% of the total African population, while membership in Methodist churches during the same period remained static at 12%. He further stated that between 1964 and 1983 the number of independent healing churches in South Africa rose from 2000 to 4000 with an approximate membership of 4-5 million people (Daneel, 1983).

African Independent Churches are defined as churches where healing (biotherapy, socio-therapy and psychotherapy) play a significant role with regards to doctrine, pastoral praxis and the recruitment of new members (Schoffeleers, 1991). Peltzer (1999) elaborated on this issue stating that, healing in South Africa's two biggest African independent church movements (Apostolic and Zionist churches) can be broken down into three stages: during

church services; by immersion which refers to residing at the church premises on a full time basis for a lengthy period of time; and through consultation with the prophet. However unlike other healing churches where healing takes place only through one stage, in these two churches, healing is of such importance that it takes place in all three stages, where the prophet is the healer who has the ability to predict, divine and heal through the power of God (Peltzer, 1999).

Daneel (1983) reported that their approach to Christianity is often referred to in theology as "realised eschatology"; experiencing the new heaven and earth in the *here* and *now* where every member is responsible for its realisation. This then results in the great focus in recruitment of new members so as to realise this new church order; where spiritual peace, material wellbeing and protection from evil spirits are the new hall marks of God's presence (Daneel, 1983).

2.2. Indigenous Healers' Perspective on the Diagnosis and Cause of Mental Illness

Flisher and Williams (2011)informed by the South African Stress and Health Study conducted between 2002 and 2004 found that, at least 30% of adults have been diagnosed with an mental illness in their lifetime (with anxiety disorders accounting for 16% of the mental illness, mood disorders accounted for 10% and 13% of the adults reported having had substance use disorders). Furthermore, South Africa has a higher prevalence of mental illness than many low-middle income countries indicating that nearly one in three South Africans will suffer from a mental disorder in his or her lifetime (Jack et al., 2014).

Kaplan and Sadock (2007) state that the western biomedical diagnosis and treatment process follows a carefully predetermined procedure, which starts from identifying the problem with the patient, administering psychometric tests and then a final diagnosis can be made. Treatment options explored follow a strict guide (Diagnostic and Statistical Manual of Mental Disorders) and also the nature of the diagnosis from the patient's perspective (Kaplan &Sadock, 2007). African belief systems however, have a different approach to the diagnosis and treatment of mental health illnesses. According to the African belief system, every illness has a specific purpose or cause and therefore the treatment of that illness comes from discovering the underlying cause (Edwards, 1986).

Edwards et al., (1983) examined the relationship between modern Psychiatry and traditional Zulu Psychiatric diagnostic systems and found that traditional conceptualization of illness is based on theories centred on natural and supernatural divisions. Furthermore, the client does not tell the healer what the problem is, instead the healer informs the client or family what their problem is and all of this is done through the consultation of the ancestors and, or throwing bones, cards or stones thus, the way the bones fall will enable the healer to diagnose the patient (Ross, 2010). In addition to the above view point, Mzimkhulu and Simbayi (2006) note that in traditional healing, the patient assumes no personal responsibility, the roles are reversed as the client assumes a passive role and the healer does all the work. However, in conventional psychotherapy the client actively works and the therapist takes a reactionary role. Even though the role of the diagnostic interview has a long honoured history in both Western and Traditional healing, the way in which it is conducted show the apparent differences between the two (Edwards, 1986).

Owing to training in secular and empirical traditions with operationally defined nosology, the Western orientated health worker puts great detail in asking detailed questions of mental status and symptom content of the disorder, while the traditional healer (the recognised medium of the supernatural cosmic world) is consulted with the specific contractual expectation to divine the cause of illness (Edwards, 1986).

Mental illness as a result of the diagnostic process can be attributed to the conflict between the individual and ancestors, or God, witchcraft or a spirit. Furthermore, Edwards (1986) argues that, illness can also be attributed to natural causes, failure in human relationships (or community relationships), spiritual pollution or the illness can be believed to be caused by engaging in an impure activity such as having sexual intercourse with a woman while menstruating, who have had an abortion or miscarried, or with a woman before she has completed her mourning period or coming into contact with faeces, corpses or death.

Edwards (1983) further notes that, Ngubane's classification system elaborates on the above by dividing all causes of mental illness into three main categories of causation, namely: Animistic theory of illness, Magical theories of illness and finally the Mystical theories of illness. Edwards et al., (1983) provided the following explanation of the above mentioned theories:

Animistic theory: this theory ascribes the illness to the behaviour of a personalized supernatural agent, such as a spirit or God examples which include “uflatelwa ngabapansti” referring to the withdrawal of protection from ancestral shades; “ukulahla amasiko” referring to the failure to perform rituals or sacrifices for ancestral shades; “ukudlula” which is failure to indulge in abstinence behaviour during prescribed periods and; “ ukutwasa” a creative illness following a calling from the ancestors to become a diviner.

According to Sorsdahl, Flisher, Wilson and Stein (2010) there is a belief that when the ancestors call a person to become a traditional healer, they inflict a mental illness on that person before the period of spirit possession begins. This is seen as a normal but special event where one is being called by their ancestral lineage to serve them as a traditional healer. Being called to become a healer means that one will inherit special powers, should he/she comply, however failure to do so will result in permanent punishment from the ancestors in the form of a psychotic spectrum mental illness “imphambano” (Edwards et al., 1983).

Magical theory: attributes illness to the covert actions of a malicious person who employs magical means to cause harm to victims. Here examples include “idliso”, which is poisoning attributed to sorcery; “umeqo”, which refers to stepping over a harmful concoction attributed to sorcery; “uvalo”, which is anxiety attributed to sorcery aimed at lowering defences; “tokoloshe possession”, which is witchcraft through a familiar, a supernatural agent of a witch and; “ufufunyane”, which is spirit possession attributed to sorcery (Edwards et al., 1983).

Mystical theory: explains illnesses as a direct consequence to an act or experience of the afflicted (Edwards et al., 1983). The healing process does not only involve a prescription of herbs or other natural products but a fundamental part of the process involves communication with the ancestors and making amends with them as they are believed to have powers that can influence one’s healing (Ross, 2010). The cause of illness however, in many cases, is attributed to external agencies whereas the Western biomedical model attributes illness responsibility and agency within the individual (Ross, 2010).

Faith healers’ process of healing is centred on the framework of Christianity where prayer is the main healing technique (Ross, 2010). Furthermore, Makhanya (2012) argues that, symptoms such as hearing voices which may be diagnosed as psychosis by the biomedical model are not necessarily viewed as a mental disorder by some traditional healers, and such

symptoms may indicate that the individual is being called by his/her ancestors to become a traditional healer and therefore must accept the calling and start with their training. However, other healers in the study conducted by Makhanya (2012) do believe that some symptoms observed among individuals may be attributed to mental disorders.

In the Xhosa tradition, Makhanya (2012) specifies that a hysterical condition characterised by speaking in an eccentric muffled voice, in a language that cannot be understood, violent behaviour and psychomotor agitation usually leads to the individual being diagnosed as having "Amafufunyana" by traditional healers. Furthermore, this condition is believed to have been caused by sorcery that leads the individual to be possessed by various spirits speaking through the individual in tongues. Makhanya (2012) cites a study conducted by Niehaus, et al., among Xhosa people, that found symptoms attributed to the diagnosis of being called by the ancestors to serve as a traditional healer (also known as "ukuthwasa") and "amafufunyana" do not necessarily differ. Furthermore, most of the patients diagnosed with these conditions by traditional healers have been linked sometime in their past with schizophrenia (Makhanya, 2012).

Even though this is the case, Makhanya (2012) notes that being diagnosed with "ukuthwasa" is not attributed to having a mental disorder due to the notion that it is a gift, whereas having "amafufunyana" is viewed as a disorder needing treatment; raising confusion on the diagnosis procedure employed by traditional healers since similar symptoms of illness can also produce different diagnoses.

Makhanya (2012) notes that, traditional healers may prefer the term "amafufunyana" to describe mental illness of psychological distress in general as the symptoms have a spiritual element and it is associated with fewer stigmas in the traditional setting of the Xhosa people than a Western orientated diagnosis of Schizophrenia.

Vontress (1991, p. 246) provides the following as diagnostic techniques used by traditional healers in Sub-Saharan countries:

1. *Anthroposcopy: the ability to tell a person who they are, where they come from, factors regarding their illnesses by just looking at their face and not receiving any prior information about them.*

2. *Lithomancy: the process of diagnosing illness by throwing of bones and other inanimate object and studying their landed configuration.*
3. *Trance states: here healers go into trance-like states or altered states of reality to visualise the cause of illness.*
4. *Bibliomancy: is the randomly turning of pages in sacred books (e.g.) the Bible, were it is said that the cause, course and treatment of the patient's illness appears.*
5. *Clairvoyance: the seeing of things invisible to normal sight informing the healer of the person's illness.*
6. *Clairaudience: the hearing of things inaudible to normal hearing informing the healer of the person's illness.*

2.3. Treatment of Mental Illness Administered by Indigenous Healers

Campbell-Hall et al., (2010) indicate that, since the Western biomedical model is grounded on understanding symptoms of illness in relation to their physiological and psychological states, it adopts scientifically based treatment options for illnesses compared to the indigenous cultural models of healing as they base their treatment of illnesses on the patient's explanatory model of illness. In this instance, little is known about the treatment administered by indigenous healers and the regulation behind it compared to the Western bio-medical methods of treating mental illnesses, however, the treatment differs according to the healer's training and healing method.

Campbell-Hall et al.,(2010) note that care offered by indigenous healers is linked to indigenous explanatory models of illness which incorporate the spiritual correlation of illness and the understanding of the individual interpretation of illness in relation to its causation, symptoms, expected course of the illness and treatment options as illness can also be associated with upsetting the ancestors through witchcraft and failing to perform rituals. The goal in indigenous healing is to restore harmony and balance among the clients, not only by alleviating the physical symptoms, but also by re-integrating the individual with his or her community and the spiritual world (Ross, 2010). This has further been indicated to include singing, dancing (Ukuxhentsa) at the patient's home whilst evocating evil spirits, culminating in feasts where animals are slaughtered as ritual sacrifices (Mzimkhulu &Simbayi, 2006).

Among the diverse previously indicated traditional healers, herbalists treat clients by prescribing herbs, medication and enemas for a range of illnesses and they are also expected to provide protection against witchcraft, to prevent misfortune, and bring prosperity and happiness (Ross, 2010). Diviners, treat psychosis by cleansing patients and their family of evil spirits through washing, steaming and induced vomiting of the patient, and in many cases the healers order the patient or family to slaughter an animal in order to be cleansed (Mzimkhulu & Simbayi, 2006; Ross, 2010).

Sorsdahl et al., (2010) in their study of explanatory models of mental illness employed by traditional healers in Mpumalanga, report that treatment may require that the patient move in with the healer for a time duration ranging from two weeks to up to a year, where a structured treatment plan is administered. Failure to adhere to it may result in the patient being forcefully restrained with chains.

Faith healers on the other hand heal through a combination of herbs, prayer which involves laying hands on patients, conducting rhythmic movements which follow some form of ceremonial dance around the patient or showering them with ash and holy water. In some instance however, patients live at the residence of the healer for months or years (Makhanya, 2012). For instance, Daneel (1970) observed during the time he spent at the Zionist Church headquarters formerly known as Rhodesia that the church itself was a hospital. This view has, thus, been reaffirmed by Bate (2001) noting that prayer healers are consulted on a regular basis at their homes, where they offer spiritual discernment of the cause of the problem to which treatment is often prayer, water for drinking and other forms of medicine.

Daniel (1970) further indicates that their headquarters have multiple huts which are reserved for the sick, where new arrivals are admitted into to await consultation for a diagnosis from the healer. Bate (2001) reported of multiple daily prayer sessions where people are received in a system of mutual aid and help (receiving treatment not only makes you financially liable to the faith healer but the recuperating patient has to work for them). Furthermore, Makhanya (2012) argues that faith healing is sometimes favoured as the principles employed by it as it is integrated with African and Christian traditional beliefs.

Although faith healing seems to be an ideal form of traditional healing, administration of treatment has to come under great scrutiny in South Africa with concerns being raised on the

effectiveness of the treatment, danger they may pose and vulnerability of patients being exploited by the healers.

A report by IOL News ("Faith-Healers anger council", 2010) indicates that some churches such as the Christ Embassy church in Johannesburg have been severely critiqued for suggesting to some of their clients during a faith healing meeting that they should stop taking their HIV medication as God has healed them, but after those suggested actions, the patients die. It has been argued that because faith healing is not based on empirical findings, its treatment procedures potentially pose danger to the lives of the individuals seeking care. This opinion has been supported by another online article ("Local faith healers sensitized", 2014) indicating that the treatment of psychiatric patients by faith healers in India are likely to lead to human rights violations, which may subject patients to torture like chaining, beating and isolation. Bate (2001) continues to state that, they teach a misguided notion of faith, which is faith in faith rather than in God; turning Christianity into a cult. Furthermore, further accuses faith healers have been accused of denying their followers medical access as they place too much emphasis on disease as spiritual in nature while ignoring physical causes Bate (2001).

Vontress (1991, p.246-247) sums up all the above by providing the following examples of the major treatment options used singly or interactively by all 3 indigenous healing systems, including faith healers:

1. *Dream interpretation: the ability to analyse dreams to uncover various fetishes about them as dreams are seen as the modus of communication between the living and dead.*
2. *Possession dances: which can be seen as the traditional equivalent of western group psychotherapy, are highly emotively charged festive occasions were people gather to await the appearance of spirits who through the medium enthral those gathered with revelations.*
3. *Sacrifices: these are animals slaughtered to appease the spirits or ancestors.*
4. *Pharmacology: the use of herbs to treat various physical, psychological and spiritual illnesses.*

5. *Shock therapy: an African styled form of shock therapy especially for the duration of mental illnesses. Here the patient is repeatedly dunked in freezing water in an effort to shock the illness out.*

The lack of knowledge regarding faith healing procedures have led to speculation and has enabled other individuals to exploit the indigenous practice and therefore indicates a need for such a study so as more evidence on the treatment procedures of traditional healers can be properly documented.

2.4. Indigenous Healing and Western Psychiatry

In the African Region, the burden of mental disorders is not being addressed adequately due to the lack of financial and human resources and the lack of early diagnosis followed by appropriate care turning acute psychotic disorders to chronic conditions (Amuyunzu-Nyamongo, 2013). Although the mental health situation in the African region is a major cause for concern, Makhanya (2012) indicates that, a critical emancipatory psychology should consider the languages, philosophies, culture and world views of indigenous people. These worldviews shape the attitude, values, opinions and behaviours of individuals especially in the diagnosis and treatment of mental illness (Makhanya, 2012).

According to Campbell-Hall et al., (2010), Western biomedical health services form part of the public healthcare system provided by the government, however, these health services have been corresponding with indigenous practitioners who provide an alternative culturally embedded system of healing for their clients. The cause of this is due to the western paradigm's insufficient resources to cater for the growing population of South Africa. For instance, Makhanya (2012) notes that the country has about 6 000 psychologists, 10 000 social workers, 30 000 medical doctors and 125 000 nurses of which about a third of these professionals' work in the private sector servicing a small portion of the country's population. The majority of the population cannot afford care in the private sector and therefore often rely on the public sector for the provision of services and also some 300 000 traditional healers and more than one million African Indigenous Church (AIC) faith healers who are easily accessible to all communities at much lower rates than those observed in the private Western biomedical paradigm (Makhanya, 2012).

Mental health problems assume the fourteenth place on the list of common conditions observed by traditional practitioners whereby mental health conditions affect 9% (although the figure might be much higher since conditions such as ancestral problems and spiritual problems are likely to be considered as mental disorders according to the Western diagnostic systems) of the clients requiring assistance (Campbell-Hall et al., 2010).

Rural areas in the country have more indigenous healers than western trained mental health practitioners and therefore service most of the mental health needs of populations residing in those areas as seeking care in the formal health sector for mental health problems is also shrouded with stigma. Therefore, Campbell-Hall et al. (2010) note that involving traditional healers with the care of common mental issues can help narrow the treatment gap of these problems in the country.

In South Africa however, there have been attempts to make the indigenous paradigm more structured so as to regulate its treatment procedures which ensure that the rights of the patients are not infringed upon. An example of this is the establishment of the Traditional Health Practitioners Act, No. 35 of 2003 (and future amendments) which aimed at establishing an interim traditional healer's council which provides registration and somewhat training of traditional healers so as to protect the public interests (Makhanya, 2012). Campbell-Hall et al., (2010) reported that even though there has been an increased drive towards the professional regulation of Indigenous Healing (including Faith healing); many still practise as they have for decades without any formal registration.

Many Faith Healers have raised concerns with how a system so deeply entrenched in cultural and spiritual thought can be regulated by the state. Concerns of being weary of how these two (Western -Traditional) healing systems, both differing in explanatory frameworks, could collaborate (Campbell-Hall et al., 2010). Furthermore, Ross (2010) reports of a South African context where 80% of health service users use both systems concurrently, further emphasising the need for collaboration between the two especially with regards to the treatment of severe mental illnesses where adherence and a biological perspective is paramount.

The above seeks to indicate that without collaboration between the two systems, where both health professionals undermine each other's treatment protocols, more harm to patients will occur. Farrand (1984) previously noted that Western orientated models have been levelled

with criticism, stating that even though they treat symptoms of illness, they sometimes lose sight of the traditional belief system at which the patient operates on, thus failing to answer the critical question of "why" the illness occurred in the first place. The consequence of this is the preferred use of indigenous healers who share the same explanatory model of causation as they do, which then has negative effects on adherence to treatment provided by the Western orientated model. For an effective collaboration between the two systems to occur, the following should be the main possible features namely:

Incorporation, Co-operation or **Total integration** (Campbell-hall et al., 2010). The incorporation or total integration of these two healing systems would prove to be challenging as they have opposite world views from which they operate. Total integration means that the two would be merged to form one healing system, a situation that seems highly unlikely as these two well developed systems have differing views on their explanation of the causation and treatment of mental illness. The merging of the two would mean that both would have to lose certain elements about themselves so as to be able to fit.

Farrand (1984) equates this scenario to trying to fit a square into a circle were both shapes would want to keep their original shape meaning a loss of shape would be seen a loss of original identity. The integration of these two systems brings the following issues to mind:

1. *"How would a system (Western) based mainly on scientific enquiry regulate spiritual knowledge?"*
2. *"Would both experts be seen as equals or would there be different hierarchal structures amongst them?"*
3. *"Which healing system would have to lose its original identity?"*

Research with the various stakeholders (mental health practitioners and indigenous healers) concluded that they all favoured the option of co-operation which would allow both systems to remain autonomous and self-regulating with collaboration occurring through mutual referrals (Campbell-Hall et al., 2010). If this is to be successful, then the following should be considered by both systems:

1. *"How both systems go about determining whether the cause of illness is purely medical or spiritual"*
2. *"A thorough understanding of the treatment regimens offered by both systems and the nature of their interaction/effects when utilized simultaneously".*

Campbell-Hall et al. (2010), report of a common belief from both healing systems that psychiatric patients would benefit from dual psychiatric and traditional systems as seeking treatment from both is viewed to be unproblematic. This mutual referral system would seek to address the issues already cited by Farrand in 1984 over the criticism levelled at Western orientated healing systems. The dual system would mean that Psychiatry with the disease problem (symptomology) while Indigenous healing would focus on the illness concerns of the patient.

While a collaborative relationship is thus seemingly the most appealing to all stakeholders, there have been few studies which have investigated how such a collaborative relationship could become a reality at district level. The lack of research done on the practical application of this collaborative approach raises concerns on whether or not this system is one which looks good merely in theory but can't be applied into our mental health services.

The research on the relationship between traditional practitioners and Western health care suggests that traditional practitioners are more open to reciprocal collaboration with medical personnel than vice versa; their openness to collaboration is despite concerns that they may be exploited for their knowledge and skills, or be viewed as having nothing to offer the health services because they lack formal medical training (Campbell-Hall et al., 2010).

Western orientated doctors have a tendency to look down on traditional healers due to their perceived lack of knowledge of the biological component of mental illnesses and as such it is very rare that they refer patients to traditional healers but would rather refer to those who share the same understanding of illness as they do, to some (Western orientated doctors) this collaboration is still seen as unfavourable (Wreford, 2005). The above scenario it hampers collaboration between Western and indigenous healers as they feel undervalued where their skills are called into question and their lack of formalized education has become their Achilles heel.

Even though the provision of mental health care by traditional practitioners may have its merits, their ability to effectively treat severe mental illnesses is still questioned (Campbell-Hall et al., 2010). The above is mainly a consequence of their lack of formalized education into the biological basis of illness; a healing system which attributes the causation of illness to spiritual entities operating outside of the individual; an inability to make a distinction between physical and psychosocial problems (Ross, 2010).

2.5. Conclusion

The objective of this chapter was to review the literature around Indigenous healing systems, with a specific focus on the role of Faith healing in the diagnosis and treatment of mental illness. The chapter was divided into four themes, where the first theme represented **the nature and training of indigenous healers**, the second theme discussed the **perspectives of indigenous healers in the diagnosis of mental illness**, the third theme explored the **treatment procedures employed by indigenous healers** and last theme deliberated the **interrelationship of indigenous and Western Psychiatry**.

Makhanya (2012) noted that, indigenous healers/ traditional healers have three broad categories; diviners (who are believed to be chosen by their ancestors), herbalists and faith or spiritual healers (who are guided by their Christianity). Diviners (Igqirha) are anointed by their ancestors through a process of “ukuthwasa” (a state of illness) where failure to undergo training from an experienced diviner results in deterioration in mental state, whilst Herbalists (Ixhwele) are normal people with extensive knowledge of traditional herbal medicine (Ross, 2010).

Makhanya (2012) reported that Faith healers (Umthandazeli) are often professed Christians who get their source of power from the almighty or trance like contact with the spirit. The biological diagnosis and treatment model follows a predetermined procedure guided by strict guides (Diagnostic and Statistical Manual of Mental illnesses); African healing systems rely on communication with the ancestors or the almighty to uncover the underlying basis of illness. Here illness is not attributed to biology by to external forces within the spiritual realm. Whereas the Western orientated treatments are scientifically researched, tested and regulated, very little is known about types of treatment options offered by traditional healing systems especially Faith healers. The chapter reported on the need for collaborative work between the two systems of healing, highlighted the positives and concerns of such collaboration.

Chapter 3: Research Design and Methodology

3.0. Introduction

The chapter is divided into three broad sections; the first section presents the Research Design of the study, which consists of the study area, the target population, sampling procedures and the duration of the study. The second section presents the Research Methodology and the research techniques employed in the study. Thirdly, before concluding, the ethical considerations including the validity and reliability principles of the study are presented.

3.1. Aim and Research questions

The review of literature indicated that, as an indigenous healing system, Faith healing has not been afforded the same study opportunities as other identified Indigenous healing systems (e.g. traditional healing), thus there is a need for studying the diagnosis and treatment methods employed in the Faith healing practice in relation to mental illness. This study therefore aims at filling that gap through the gathering of information/data utilising the study design and methodology identified in this chapter, in an effort to address the specific research questions identified below:

1. How do self-identified faith healers describe their training and preparation to become faith healers?
2. How do self-identified faith healers view presentations of mental illness?
3. How do self-identified faith healers understand the causes of mental illness?
4. How do self-identified faith healers understand the treatment options?
5. How do self-identified faith healers collaborate with the medical model of understanding mental illness?

3.2. Research Design

According to Babbie (2011), research design is a specification of the most adequate operations to be performed in order to test a specific hypothesis under given conditions or the planning of any scientific research from the first to the last step. This study was designed taking into consideration the following, study area; the target population; the sampling techniques and sample size; and the duration of the study.

3.2.1. Study Area

The area chosen for the commencement of the study is located within the Chris Hani District Municipality in the Eastern Cape Province of South Africa. The district is located in the north-eastern part of the Eastern Cape and is a linking node to all other eight districts located in the province. The Chris Hani district is further divided into six local municipalities namely, Enoch Mgijima, Instika Yethu, InxubaYethemba, Engcobo, Sakhisizwe and Emalahleni. The data was collected is located within the demarcation of the Intsika Yethu local municipality.

According to Statistics South Africa (2014), Intsika Yethu municipality caters to outlying rural settlements with a total population of 145 372 people, of which 99, 4 % are black Africans with other population groups making up the remaining 0.6%. The study area was chosen due to its overwhelmingly high percentage of black Africans within the population as this increases the chances of finding the chosen respondents, especially because the area is made up of rural settlements.

3.2.2. Target Population

The target population of this study was Faith healers from the Chris Hani District in Intsika Yethu municipality, an area made up of rural settlements approximately 100km from Queenstown. The target population was not gender specific meaning that both male and female respondents were included within the study. Faith Healing is considered a gift that only a few individuals possess thus; this study did not consider equal gender representation of the respondents due to limited available respondents in the study area.

3.2.3. Sampling and Sampling Procedures

3.2.3.1. Sample Size

According to Babbie (2011), a sample is a subset of the entire population under study in which the findings of the study could be generalised. A research study sufficiently represents the population by identifying a sample that has all the qualities of the population under study however, due to the scarcity of individuals who identify as Faith healers in the study area (since Faith healing is regarded as a special gift that only a select few possess), a sample of 4 Faith healers were identified for inclusion in this study. This then meant that, due to the limited scope of the sample size, the findings of the study could not be generalised to the

entire population of Faith healers in South Africa but rather to those residing in the Chris Hani District Municipality.

3.2.3.2. Sampling Techniques

Babbie (2011) argues that sampling techniques describe the process of selecting subjects when it is impossible to have knowledge of a larger collection of these subjects. Non probability judgmental sampling techniques were utilized in the study as the researcher used his own prerogative in identifying and approaching respondents (Babbie, 2011). The purpose of this chosen technique ensured that the error in interviewing inappropriate respondents was eliminated thus ensuring that only those respondents (Faith healers) with the necessary expertise were chosen during the data collection phase; this then ensured that the data collected met the objectives of the study.

Inclusion criteria of the study required respondents to identify as Faith healers thus practise Faith healing within the research area. Furthermore, respondents were included on the basis of their adequacy (expertise/experience in their calling as Faith healers) to provide data that sufficiently satisfied and answered all research questions laid out in the study. Their adequacy was determined by the number of years practising Faith healing (respondents were required to have had at least been practicing Faith healing 5 years and above). All Faith healers included in the study are leaders/bishops in their respective churches.

3.3. Duration of the Study

The proposed duration of the data collection was a week (5days), whereby the researcher conducted in-depth interviews with all research respondents (Faith healers). Each respondent was allocated a day where the interview was conducted. All interviews were not restricted by a set time frame which ensured a rich data collection process where research questions were answered to their smallest detail.

3.4. Methodology

The proposed Thematic study utilized a qualitative methodology since it explored phenomena which couldn't be quantified using statistics, but encoded themes arising from the data collected. Qualitative methodology uses qualifying words to solicit information from respondents that aid in answering the research questions (Babbie, 2011). The data collected

gave explanations to the qualitative responses of the respondents, it allowed for more probing so more information that answered the research questions was gathered. Furthermore, the chosen research methodology also explained any behaviour (non-verbal communication) observed from the Faith healers during the data collection process. This non-verbal communication also formed an important part of the findings of the research.

3.4.1. Research Techniques

Babbie (2011) states that, research techniques are the various ways by which data is collected. This study made use of semi structured interviews/ in-depth interviews (appendix 1: Interview Schedule) as its main research technique. However, during the data collection, the observation of various attitudes, symbolisms and non-verbal communication also informed some of the findings regarding the meaning attached to objects/symbols and also to the ultimate practice of Faith healing. Observation data of the geographical spaces of practice, such as dwellings and churches was also included as part of the data to situate practices within a specific context of practice.

3.4.1.1. In-depth Interviews

An interview is noted by Babbie (2011) as a dialog between a skilled interviewer and an interviewee. Furthermore, Clark-Carter (2004) defines semi structured in-depth interviews as ones guided by an agenda with set questions that need to be answered by the respondents, however the wording or order of the questions is not fixed. Utilizing this interview style offered the respondents a degree of flexibility, the opportunity to use their own wording in describing their experiences thus allowing for a flowing data collection process. Mzimkhulu and Simbayi (2006) state that, the purpose of these interviews is to allow for rich descriptions of the respondent's experiences in their own words. This interview style was most suited for the study as it was non directive but allowed the respondents to fully account for their experiences as healers thus providing rich data in the attempt to answer the research questions.

All four interviews were conducted in the language chosen by the respondent, however taking into account that the Faith healers that were included in the study are based in the rural areas therefore the dominant language of choice was isiXhosa. All interviews conducted were

recorded using audio recorders, transcribed and translated back to English. Even though interview schedules (refer to appendix 1: Interview Schedule) comprising of open ended questions were drawn up to direct the interview, the researcher allowed deviation from it so as to ensure that the Faith healers gave rich accounts of their practice without being stopped mid-sentence. Furthermore, observing the visual depiction of practice structure (i.e. visual effects such as candles, same colours painted in and outside of their churches, etc.) also allowed for further probe into the meaning placed on certain items within the indigenous healing paradigm.

3.4.2. Data Analysis

Data analysis is a process of transferring raw data into variables that can be analysed to produce information constructed by the researcher (Babbie, 2011). Analysing the data enabled the researcher to find answers to the posed research questions and also gave a clear indication of the influence of Faith healing on the diagnosis and treatment of mental illness in the Eastern Cape. The analysis was conducted using the thematic analysis approach (Braun & Clarke, 2006) whereby the data is described in rich detail through the extraction of themes/patterns in the data to answer the research questions.

The themes identified captured the important questions that the study aims at answering however, these themes were not limited to the responses provided by participants but rather an important pattern that captures the essence of the study.

3.4.2.1. Coding using a Thematic Framework

Babbie (2011) noted that coding is the process of transforming qualitative data into a standardised form that will be suitable for processing and analysis. In thematic analysis, Braun and Clarke (2006) note that, themes/patterns can be identified in two primary ways; the inductive approach (also known as the bottom up approach) and the theoretical approach (also called top-down approach). In the inductive approach, themes identified are strongly linked to data collected meaning, the themes identified may bear little relation to the specific questions asked from the respondents (Braun & Clarke, 2006). The theoretical approach however, tends to be driven by the researcher's theoretical/analytical interest in the study. It

then therefore provides less description of the data overall and more detailed analysis of some form of the data instead (Braun & Clarke, 2006).

Coding in this thematic study has been conducted through the guidance of the inductive approach, which meant that the themes identified had little resemblance to the research questions. Thus, coding with the aim of answering the given study question with data collected.

The inductive approach was also used because of the limited literature referring explicitly to the study of Faith healing in relation to western healing paradigms of mental illness, thus allowing the researcher to provide themes as the data indicates to be able to answer the research question. The coding process lead to the development of dominant themes (themes deemed to be addressing the research question and were relevant within the data set) that provided insight to answering the research question. The themes generated provided a platform to substantially correlate the nature of Faith healing in the study area to that of western orientated healing thus, making it easier for us to understand and interpret the phenomena of Faith healing. All the main themes generated and comparisons drawn are discussed in the results section of this thesis (chapter 4) which also compares and contrast the similarities or differences in the findings with other already identified literature.

3.5. Ethical Considerations

The research was subjected to ethical considerations of the Rhodes University Research Ethics Standards Committee (RUESC). Furthermore, it was the responsibility of the researcher to convey these considerations to the respondents and ensure they provide a written description to being informed about the study and its ethical issues (see appendix 2: informed consent) before conducting the research. Informed consent was obtained through a letter detailing the research topic; the purpose of the research; the ethics applying to the respondent and researcher. Furthermore, the letter informed all respondents what was required of them. The letter also touched on the issue of confidentiality, whereby the respondents were assured that their responses will not be shared with anyone, or that the responses will not implicate the respondents in a negative manner and that all data collected will be used for research purposes only. Furthermore, it also assured them that all data would

be discarded safely after the study has been completed (such as the photos of their dwellings, which all they gave permission to the researcher to take).

A research project guarantees anonymity when the researcher cannot identify a given response with a given respondent (Babbie, 2011). Anonymity of the respondents in the study was not guaranteed as the respondents were "known" to the researcher. This meant that the researcher could identify a given response with a given respondent. However, strict rules of confidentiality were adhered to in an effort to protect their individual identities. An example of this included giving all respondents pseudonyms (e.g. Respondent A, B, C or D). Just as the knowledge, use and interpretation of psychological protocols is governed by scope of practice as stated in the Health Professions Act no56 of 1974, the intricate cultural and spiritual knowledge of traditional healing practices is governed by Traditional Healers Bill (South African National Department of Health, 2003). This could prove to be a major hurdle for data collection as the respondents may feel that prohibited from sharing their knowledge with people not versed within their discipline, so this hurdle was tackled by addressing the issue of confidentiality in depth.

The researcher maintained this by ensuring that all information collected during the interviews was stored in a safe place, secondly only those involved with the research process had access to the collected data. This then presented as a critical issue as the data collection may be an invasion of secrets personal thoughts and activities, so harm of any nature as mentioned by Clark-Carter (2004) to the respondents was avoided.

Lastly it was important to address with the respondents the issue of findings and conclusions drawn from the study. Here the researcher asserted that the aim of the study was not to make negative conclusions about their practice, not to discredit them for their lack of formalized education but rather to gain insight into alternative treatment options available/utilized by people in an effort to promote future collaborative work between the two viewpoints (Western–Traditional) thus ensuring increased quality of mental health services rendered to people.

3.5.1. Reliability, Validity and Trustworthiness

As researchers, we seek to ensure that all our work is based on pre-established standards of conducting research so that our research findings are viewed to be both valid and reliable (Morrow, 2005). The validity and reliability of our work ensures that the findings generated by the study are trusted by our readers, so as to allow for the appropriate implementation of strategies that the research aimed to address. The validity of a study enables other researchers to take an interest in a subject matter and also conduct similar studies in the same or different area, so as to be able to identify whether or not similarities in findings will occur (Morrow, 2005). The above mentioned notion acts as an instruction to researchers to adhere to the principals of Credibility, Transferability, Dependability and Confirmability, in an attempt to gain the trust of all readers who study the findings of this study.

3.5.1.1. Credibility (Internal Validity)

Shenton (2004) refers to this as the congruency of findings to the situation being observed, while Morrow (2005) elaborated on the above stating that, it is the process of ensuring that internal consistency has been maintained and how we communicate to others that we have maintained it. The following was observed by the researcher with regards to the credibility of this research as guided by Morrow (2005):

- A thorough understanding of the literature surrounding the subject area.

The researcher studied numerous articles on indigenous healing systems (including Faith healing) and other similar studies conducted by other researchers in this area of study in attempt to be familiar with the available literature on Faith healing. This familiarity with literature has been presented as Chapter 2(literature review) of this study.

- Allowing research participants to refuse to take part in the study.

This was critical in ensuring that the respondents (Faith healers) didn't feel forced into the study, so as to be able to facilitate effective/valid contributions. This allowed only those who genuinely wanted to participate in the generation of knowledge to be part of the study, thus minimizing the risk of being fed false information by respondents and allowed for rich data collection. The study addressed this issue by offering a consent form to all respondents that explained the nature of the study and what was required from them at the onset of the data

collection. The researcher informed respondents of their rights to refuse to take part in the study during the rapport establishing phase to ensure that only those genuinely interested formed part of the sample.

- The use of multiple data collection techniques (Triangulation)

This study not only made use of semi structured interviews but also observation as a data collection tool. This ensured that we not only record what is being said but also how it is being said as well as the physical context in which it is being discussed or enacted. This then created a richer data analysis process through the use of an established/trust methodology (Thematic analysis) in this particular field.

- Pro-longed engagement with the respondents to ensure rich data collection

The duration of each interview (spending a day with each respondent) addressed this issue. All interviews were not restricted by a pre-set time frame which allowed respondents to give their account of Faith healing practises to their fullest description. Furthermore, the use of audio recorders ensured that all information was captured during data collection.

3.5.1.2. Transferability (External Validity)

Transferability refers to the extent to which the findings of the study can be generalized to the larger population (Shenton, 2004). A major challenge in conducting qualitative work lies within a limited number of participants that are included in the sample, making it difficult to truly generalize the findings to the larger population. Morrow (2005) explains the above situation as a consequence of the ideographic nature of qualitative research.

The study had a sample made up of only four Faith healers from the Chris Hani district. This sample had two main characteristics that made it difficult to generalize the findings to the entire population of faith healers in the country, namely sample size and geographic location. This meant that the findings of the study were generalized to faith healing systems within the Chris Hani district, while inviting other researchers to take on similar studies in other provinces thus allowing for future comparative studies of Faith healing systems in South Africa.

3.5.1.3. Dependability (Reliability)

Shenton (2004) refers to this as 'the extent to which a similar study can be conducted by a different researcher at the same location and arrive to similar findings'. Morrow (2005) stressed the need for this study to be seen as a prototype for which future researchers can use to replicate this study.

The researcher has ensured that this is possible by outlining all the steps that were taken prior, during and post data collection in a detailed research design chapter (here within chapter 3). This research design which entails the location of the study conducted, the chosen sampling techniques utilized, data collection tools and analysis procedures will allow future researchers a chance to replicate the study with the aim of arriving at similar conclusions.

3.5.1.4 Confirmability (objectivity)

Shenton (2004) stated that 'this refers to the extent to which findings represent the studied situation and that all conclusions drawn represent the experiences of the respondents. Morrow (2005) elaborated on the above stating that the researcher should guard from reporting data in an effort to fit his/her pre-conceived theories, hypotheses, beliefs or stereotypes but should do so based on the raw data collected from the respondents. The researcher made use of a data orientated audit trail, where he provided extracts from the original data so as to highlight how he arrived at his respective conclusions. Furthermore, the use of a pre-established/widely used data analysis framework in this respective field of study also ensured credibility.

3.5.1.5. The Interview Process

The purpose of this sub-theme is to showcase the practical application of the methodological concepts chosen for the study. Non-probability judgmental sampling was utilized by the researcher in choosing candidates for the sample, where only self-identifying faith healers from the demarcated research area were chosen. The researcher who also originates from the chosen research area utilized the help of ward counsellors in his attempts to gather the sample group for the study. The ward counsellors provided a platform during their fortnightly meeting with people from different rural settlements, where the researcher was able to engage those present about the prospective study. This engagement was aimed at informing the people about the nature of the prospective study, the importance of such a study and the

need for prospective respondents for the study. Through “word of mouth”, the researcher was able to gather multiple contact details of potential candidates. After initial telephonic contact with all individuals on the contact list, only those who were deemed to fit the criteria for the sample were chosen to be part of the sample group. The researcher then made follow-up contact with the candidates chosen for the sample group to schedule interview sessions with them. The follow-contact also allowed the researcher to further explain the nature of the study, what was required from them and where they would like the interview session to take place. All four research respondents opted to be interviewed at their place of residence, offering the researcher an opportunity to observe them in their everyday reality.

The interviews were conducted on the agreed upon dates and venues as per the request of the respondents. There was no identified time duration for any of the interviews, as time pressure could have hampered the detail to which questions were answered. During the process of analysis, the researcher was able to ascertain that the average interview with each respondent lasted for an hour and ten minutes. After each interview was concluded the researcher was taken on a guided tour of the respondents’ church site, where the significance and function of each dwelling was explained. This further added detail to certain research questions in the interview guide. Furthermore, all respondents allowed the researcher to take pictures of their church sites, allowing for further discussion during the analysis phase of study. All interviews were conducted over a course of a week.

After all interviews were conducted, the focus shifted towards analysing the raw data collected from all for interviews. The point of departure at this point was transcribing each interview before translating them to English, as all interviews were conducted in the preferred language (isiXhosa) of the respondents. This process of transcribing and translating raw interview data, tedious work as it may be, allowed the researcher to re-familiarize himself with the interviews. The researcher was only able to start the coding process, after having read all translated transcripts multiple times. This coding of data allowed for the formation of dominant themes, in an attempt to answer the research questions. These themes where broadly discussed in Chapter four (Results and Findings) of this study, where the researcher drew comparisons and conclusions between all three indigenous healing practises and the Western orientated psychiatric model.

3.6. Conclusion

This chapter highlighted the research area, methodology employed in the study, and also the techniques employed. This study was conducted in the Chris Hani district, an area made up of rural settlements approximately 100km from Queenstown, Eastern Cape. The study used Qualitative methodology offering the researcher a comprehensive method of acquiring accurate data. The respondents were selected using Non probability judgmental samplings techniques and the sample consisted of four Faith healers. The respondents chosen provided the necessary expertise to allow us to answer the research questions of the study. The use of in-depth interviews and observations allowed for a rich a data collection process.

The Data collected was coded using a thematic framework so as to draw up dominant themes arising from the raw data in an effort to answer all research questions. All ethical considerations were taken into account prior and during data collection which ensured no harm was caused by the study on the respondents. Lastly, all principals of validity and reliability were addressed in the chapter and the researcher abided by them during the data collection, analysis and reporting stages of the study to ensure it gains and maintains credibility.

Chapter 4: Results and Discussion

4.0. Introduction

The following chapter presents the results of the data collected from the chosen sample group made up of four Faith Healers. It attempted to explore Faith Healing as an African belief system and its influence on the diagnosis and treatment of mental illnesses in the Eastern Cape Province in South Africa. The scope of this mini thesis did not allow for a broader focus (as previously noted in the abstract) and the available sample group did not allow for the inclusion of members from different African Independent Churches, but rather members of one prominent African Independent Church Movement only. What this meant is that findings to be discussed are examples of principles that can be applied across different African Independent Churches. Here all raw data was analysed using a thematic framework (see Braun & Clark, 2006) where the dominant and sub-dominant themes arising from the data have been presented. Their presentation is followed by discussion that seeks to link them to the literature reviewed in previous chapters as well as show contradictions. Audit trails of the respondents verbatim were also included to substantiate the chosen themes. In its attempt to answer the main research questions this chapter was broken down into the following six sections namely:

- General characteristics of the sample (including the researcher's observation)
- Nature and duration of training required to be a Faith healer
- Faith healers' perspectives on the diagnosis and cause of mental illnesses
- Treatment administered by Faith healers to combat mental illnesses
- Faith healing and Western Psychiatry
- Conclusion

4.1. General Characteristics of the Sample

Of the four respondents interviewed, three of them were males and one was female. Only faith healers were chosen to be part of the sample and all respondents were interviewed at their respective homes.

4.1.1. The Dwellings

Figure A

Figure B

Figure C

Figure D

All four respondents gave verbal permission for a single photo of their homes be taken and included in the study for the enrichment of the data collected. Each dwelling is seen by the respondents as their church or as respondent B referred to as "ICHIBI" stating that ***R: Yes, we call it a church, however the previous generation of faith healers used to call it "ICHIBI" or a garage where people come to fix their bodies, with prayer being the main working tool"***. To the researcher these dwellings resembled indigenous styled psychiatric hospitals because just like Western styled hospitals people (the ill) are admitted here and kept until the faith healer sees it fit to discharge them. All dwellings have multiple houses on each property said to serve the following uses:

- The church house: one house used as the church hall where all church and prayer meetings are held
- The faith healers private residence: which acts as the healers private space and bedroom
- The helpers residences: all dwellings have a house researved all the people who work for and with the faith healer on a day to day basis
- The church kitchen
- Patient housing: all dwellings have multiple gender specified housing for all the sick people recieving care at the church

4.1.2. The Blue and White Colour Scheme

Just like in Western styled hospitals were certain colour schemes are identifying aspects of certain professionals (e.g. the doctor and his/her crisp white lab coat, nurses, who previously

used to wear navy/white uniform with red epaulettes), the same is true with Faith healers where blue and white is the main colour scheme of their regalia. Not only are these colours significant with regards to the clothes that they wear but also with regards to the way in which their dwellings/ churches are painted (as evident in all of the above included pictures). This colour scheme is what informs people that they belong to an African Independent Church. Recurring dreams about oneself wearing this type of regalia is seen as proof that one is being called to be a faith healer, as in the words of Respondent B***: I sometimes hear people who are traditional healers saying that they dreamt about "intsimbhi emhlophe" or some say they dreamt that they had a cow's tail in their hands. I never dreamt about any of those things, when I saw that I wasn't well, before I even become a faith healer, I dreamt about myself wearing a blue and white church uniform;holding a gold walking stick***. Even though the researcher couldn't take any pictures of them in uniform their description is as follows: males wear a blue blazer/jacket, white shirt, blue tie and grey pants whilst females wear a white headwrap, white jersey and blue tunics.

4.1.3. Prayer

Prayer formed an integral part of all interactions with the respondents as all of them requested that we pray before commencing with each interview, stating that they couldn't talk about the work of God without first calling on him to be part of the conversation. The same applied to the end of all sessions as most thanked the presence of God in the session, who has granted them the wisdom and gift to enable them to answer questions posed on them.

4.1.4. The Candle

The candle was also observed to be an integral part of the faith healers practice as all the interviewed respondents had a one "lit" in their consulting rooms. *Permission was granted by one of the respondents to take a photo of this for illustration purposes:*

Figure E

This was explained as a means of inviting the angels who govern their practice into the consulting room to guide them in their work. It was revealed that nothing can be done before a candle has been lit and the following extracts taken from two of the respondents elaborated on this:

Respondent A

R: we light our candles to speak to the heavenly angel who has granted us this spirit and pray

R: everything I do is guided by prayer, I pray for everything that I give them, that I do to them and I have to ensure that all the candles are lit before I give them any medication to drink or before working on them

Respondent B

R: as I have have previously mentioned, we faith healers heal through prayer and that means that the first thing we do when a person arrives here is to light the candles in this room

L: yes

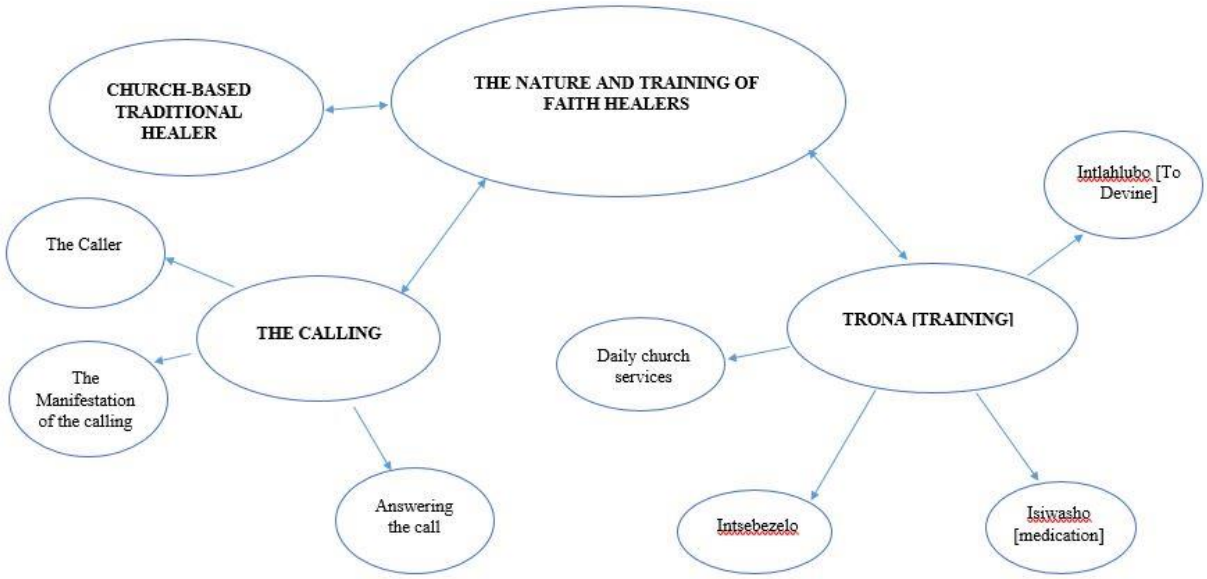
R: and invite the angels that govern the holy spirit to be with us in what we are about to do, then I start praying, asking for help and strenght from god. I told you that a person doesn't tell me their illness when they arrive

The above two extracts show that faith healers view the "lit" candle as the first point of departure in their divination.

4.2. Nature and Duration of Training Required to be a Faith Healer

The nature and duration of training required to be a Faith healer puts focus on three main aspects of the discipline, namely the respondents' definition of faith healing, the calling and the Trona (training). All respondents reported to being prayer healers, the alternative to traditional healers who have been called to serve. The respondents reported that their respective journeys in Faith healing began after answering the call to serve and after having undergone the rite of passing of the Trona (the training).

Illustration 1: The Nature and Training of Faith Healers



THEMATIC MAP 1: The Nature and Training of Faith Healers (showing three main sub-themes: Church- based Traditional Healer, The Calling and Trona]. Source: Authors' own creation

4.2.1. The Church Based Traditional Healer

The respondents reported that they see themselves as church based traditional healers who, just like mainstream traditional healers, have been called to heal people through prayer. Respondents C and D who coined the term "church based traditional healers", refer to themselves as christian seeres who pray to heal people Respondent C***: "a faith healer is church based traditional healer"***. They reported that one can define faith healing as the equivalent of the traditional healer (igqirha) however, unlike in traditional healing where the healing practice is centred on the ancestors, theirs is centred on the church through prayer Respondent D**: *"everything that I have mentioned about tradtional healers also happens to***

us but differs, we also get a calling from the ancestors but instead of being traditional healers, we answer our calling through the church, God is stronger, we also go and "trona" besides a faithhealer and thereafter we are able to see/divine and heal". Respondent A and B further added to the notion of healing through prayer by stating that, Faith healers are vessels of the Holy Spirit who have the ability to heal a variety of illnesses ranging from physical to mental illnesses Respondent A***: "a faith healer is a healer, someone who has been gifted to heal through prayer"***. They reported that prayer combined with the random paging of the bible results visions that allow them to identify the nature, cause and treatment needed to heal illnesses Respondent B***: "you see it by looking at them, when we were still in training, we were taught to be able to see the type of illness a person is suffering from, we were given a bible and were told that where we open it, one will see that the person's problem is either this or this"***.

The notion of being a "vessel for the Holy Spirit to work through" is in congruence with the view held by Vontress (1991), who reported that many Africans believe in a vital force that directs the universe. He further noted that this force is either controlled by God or Ancestors and those who are able to tap into it gain the power to heal (Vontress, 1991). It is from tapping into this power, which the respondents refer to as being "vessels", that has granted the respondents the ability to heal. The term "church based traditional healer" supports the view held by Bate (2001) that the faith healing has borrowed from many techniques from traditional healing. Viewing themselves as equivalents of traditional healers echoes Mzimkhulu and Simbayi (2006), who stated that Faith healers share a common theory of health and disease with other indigenous healers', divine in a similar manner; treat various diseases with herbs and remedies. The respondents who view themselves as equivalents of traditional healers strengthen the view that faith healing has led to a dramatic shift away from the reliance on traditional healers for indigenous healing (Pfeiffer, 2005). The respondents' views do not dispel the environment of growing animosity between the two healing modes (Edwards et al., 1983). Their "God is stronger" view directly implies that the ancestors are weaker thus one might argue that they view traditional healing, which is centred on the ancestors, to be a lesser form of healing. Edwards et al. (1983) who noted that the centre of animosity between both indigenous healing modes lies on the battle for superiority, and this stems from the debate about which controlling deity is stronger than the other. As noted, the

respondents who are controlled by the Holy Spirit view God as the ultimate supreme being while in traditional healing the Ancestors are given that same honour.

4.2.2. The calling

All respondents reported that the journey to becoming a Faith Healer is not one which a person decides for themselves, but rather a calling to serve that is given to them. They reported that Faith Healing within itself is not their chosen profession but a way of life that chose them. They reported that their power to heal is a gift bestowed on them by higher powers through a calling.

Respondent A

L: I hear you, is faith healing a calling or profession?

R: Yho(exclaims), this is a calling, a hidden calling that one shouldn't play with, here one cannot go around advertising/calling people to come to him so that their illnesses can be healed, like we read about in the papers, that's not it, those people are leading people astray. Healing should be done in a particular way, not like these money hungry people and their lies (angrily scoffs) ... (Coughs). One should do this with the aim of helping people and not to make money

Respondent B

L: and what made you become a faith healer, was it a personal choice?

R: It wasn't a personal choice, I was directed by the faith healer I went to, the one who is still my mentor.

Respondent C

R: but what I'm trying to explain is that when it comes to being a diviner or faith healer, you do not choose it for yourself but you will go through steps of starting to experience visions, after following up on those visions, you will therefore be what you were meant to be.

Respondent D

R:yes that's correct, I started on this journey from a young age...but then again one doesn't choose when they will recieve a calling...when it wants you, it wants you...

All the extracts above indicate that one doesn't just become a faith healer because it was something that they had always wished for, but that the journey to being a faith healer starts with a manifestation of a calling. Even though all respondents reported that for one to fully receive their power to heal one must first accept (answer) the call, differences arose with regards to their understanding of who gave them the call and how it manifests.

4.2.2.1. The caller

Even though the respondent defined themselves as church based traditional healers who are governed by the Holy Spirit in their practice, three (B, C, D) of the four respondents reported that their calling is one that has been gifted to them by their ancestors, not the Holy Spirit(Respondent B) ***R:I was sick then I went to him and he "hlahluba", he told me, he gave me the book (bible), opened it and told me that I'm not sick but that I needed to work for my ancestors (***Respondent D***) R:that's traditional healing, everything that I have mentioned about traditional healers also happens to us but differs, we also get a calling from the ancestors but instead of being traditional healers, we answer our calling through the church***). They reported that even though their call to serve was bestowed on them by their ancestor's certain issues led them to answer their calling (iMvuma kufa) through the church by appeasing their ancestors rather than becoming traditional healers. Respondent A reported that he was aware that some Faith Healers get their call to serve from the ancestors but choose to be Faith Healers rather than traditional healers. However, his calling was directly from the Holy Spirit and not the ancestors stating ***"R: some other people who are also faith healers were first called upon to become traditional healers, but because they are born again Christians and do not subscribe to traditional cultural practices answer their calling what we call "iMvuma kufa" through the church thus becoming faith healers. That never happened to me, I was called by the Holy Spirit from onset, in fact my dreams even instructed me of the church that I had to go to, and even the bishop at the church dreamt that I was coming there even before I arrived"***

4.2.2.2. The manifestation of the call

The manifestation of the call refers to the way which individuals report to have experienced their calling. The way in which the calling manifests itself is unique to the individual who is

experiencing it; however, the respondents reported that the main manifestations of a calling are either through physical illness, dreams or a combination of both. Respondent D reported that his calling manifested through physical illness. He reported suffering from seizure from a very young age, stating that conventional medicine failed to improve his condition but that the frequency of seizures increased as he grew older.

L: you said your father finally decided to take you to see a healer because your illness was getting worse

R: yes because of its frequency each month and because he could see that it was also starting to affect my mind

L: how so?

R: it was as if I was mentally ill after it happened

Respondent D reported upon arrival the faith healer told him that his illness was a manifestation of his calling to be a healer and failure to accept the calling would only worsen the presentation of symptoms and so he had no option but to accept the calling. Respondent A reported of a calling that only manifested as a dream stating, "***in my case, as I was growing up, I started having dreams about church, these dreams instructed me to go to church, so I got tired of dreaming the same dreams and decided that I needed to go, upon my arrival it was revealed to me that this was the place that I have been called to"***. Respondents B and C reported of a mixed presentation of the manifestation as it occurred both through illness and dreams. What was uniform in all four accounts given by respondents was that they had to accept the calling in order to improve symptom presentation while increasing their ability to divine.

4.2.2.3. Answering the call (iMvuma kufa)

The process of accepting the call is seen as an integral part of the transition to being a faith healer. "IMvuma kufa" refers to the process of accepting the call given to you by ancestors or in the case of respondent A, God. All respondents reported that this happens after each individual has consulted either a traditional or faith healer who informs that that they have a calling to heal. Respondent D defines, ***"ukufa" as a calling, when you "uvama ukufa" it***

means that you accept the gift that has been given to you by you ancestors", while respondent B also shared the same view he further stated that ***"you are then told that for your ability to divine it to continue you need to do "iMvuma kufa" as per Xhosa customs"***. All four respondents reported that the "IMvuma kufa" or "accepting the calling" involves ritual animal sacrifices. Here respondents reported to have slaughtered a goat to give thanks to their ancestors for having blessed them with the gift to heal while pledging that they indeed welcome the opportunity given to them:

Respondent C***: the "iMvuma kufa is done by using a goat and your family members when speak drive you to be able to really divine.***

Respondent D***: thereafter you slaughter a goat for them, telling them that you intend to go and "trona", as I have already told you***

Respondents A and B elaborated on this issue stating that for those who have been called by their ancestors to be traditional healers but opted to be faith healer an additional sheep is sacrificed after the goat meat has been eaten to appease the ancestors; Respondent A***: "asking permission involves taking a goat to the kraal, slaughter it whilst stating that you accept the calling afterwhich a faith healer is asked to come to the kraal and slaughter a sheep after the goat meat has been cooked and appeal to the ancestors that you wish to follow your calling through the church."***

Answering the call after having accepted the calling either from God or the ancestors can be seen as the midpoint in the journey to being a Faith Healer. The second part of the journey as reported by the respondents is the "Trona" or training one has to undergo in order to be a fully qualified Faith Healer.

The account given by the respondents indicate that being chosen by the ancestors through a calling to heal is not just unique to traditional healing but is also the initial stage of their journey into Faith healing. Three of the respondents who reported that their calling came from the ancestors contradicted the view that the only category of indigenous healers who are chosen by their ancestors to heal are traditional healers (Makhanya, 2012). Their accounts over the lack of personal choice into the journey of Faith healing, where they state

that their chosen profession is something that they were called to do as agreed with that held by Makhanya and Simbabyi (2006), who noted that ony herbalist get to choose.

This view highlights the three categories of indigenous healers noted by Ross (2010).It is only herbalist who chooses to become a herbalist (similar to Western orientated health worker) while the other two have no personal choice but are called by their ancestors. Both indigenous healing categories identify their calling through many forms which can include a dream, a vision or a feeling. Other times, the calling is believed to make them sick and if the calling is ignored that individual remains sick until they accept it (Ross, 2010). This further strengthens the debate that similarities can be observed between the two indigenous healers' diagnosis and treatment procedures as they both require the consultation of the ancestors or spirits for guidance (Schoffeleers, 1991). It is these similarities between them, the view that the Faith healer has taken the roles of the traditional healer that has also further added to the animosity between the two healing modes.

Even though the respondents contradicted Makhanya (2012) when asserting that only traditional healers are called by their ancestors to heal, they however do agree with his view that Faith healers are guided by their Christianity. The respondents who all view themselves as Christians and are all members of the African Independent Church movement (Makhanya, 2012) believe that their healing power comes from the "Almighty" through euphoric states and trance contact with a spirit. Simply put, even though the calling was from the ancestors, they answered it through the church opting to be Faith healers rather than traditional healers. New knowledge was generated with regards to the "exact process" of answering the call through ritual animal sacrifice, as this wasn't clear in previous literature. Even though Mzimkhulu and Simbayi (2006) report on ritual animal sacrifices during the treatment of illnesses no literature reported on animal sacrifices during accepting the call. However, Sorsdahl, Flisher, Wilson and Stein (2010) report a belief that when the ancestors call a person to become a traditional healer, they inflict a mental illness on that person before that the period of spirit possession begins. So, because both indigenous modes of accepting a calling from the ancestors, the calling does take the form of an illness as reported by the respondents. One might argue that accepting the call through animal sacrifices is in fact treating the illness. The physical illness treated which Edwards et al. (1983) refers to as a

creative illness signalling the call to serve the ancestors is believed to be treated only when the person accepts the call. This view is supported by the accounts given by the respondents who reported that all physical symptoms or dreams that they were plagued with stop occurring after they accepted the call. So by offering ritual animal sacrifices to answer the calling, they treated the presenting symptomology.

4.2.3. The Trona (training)

All four respondents reported that after accepting the call one has to undergo training by the faith healer chosen for them or in the case of respondent C. All respondents reported that training was done at the respective faith healers house, where they had to stay until training was completed (for 3 to 4 years). All four reported that the process of staying at the faith healers house during the training is known in faith healing terminology as the period of "Trona"

Respondent D:

L:yes...I hear you talking about "trona", what do you mean by that?

R:it's the time you spend at the person's house who is responsible for your healing or training..when people say you are at the "trona", it means that you have left your home...where you were born...you have gone to stay with the person who will heal you

All for respondents gave similar accounts of the training that they underwent under the different faith healers from which the following main aspects of the Trona (training) were drawn:

4.2.3.1. Daily church services

All respondents reported to attending multiple church services daily, where their respective faith healers would lay hands on them during prayer sessions. The respondents reported to morning church services held between 4am to 6am, a midday service as well as a night service which would begin between 7pm to 10pm (Respondent B: "***yes, we also hold church services at 5am, at 1pm and at 7pm daily***"). The function of these multiple church services was so as to invite the Holy Spirit to be with them, to strengthen its power in them and to teach them the intricacies of the bible (Respondent A: ***"we stayed at the church base, what we call "ukutrona" (coughs), where we held church services every day, praying, being taught the***

bible by other faith healers, they laid hands on us, "be sisebenzela", they were harnessing and strengthening the holy spirit within me")

4.2.3.2. INtsebenzelo (Purgatives and emetics)

All four respondents reported to the use of purgatives and emetics twice a week, mainly on Wednesday and Saturday, the days that they refer to as days of "INtsebenzelo". Respondent C defined "iNtsebenzelo" as ***"the service that induces diarrhoea, vomiting and medicated bathing that I'm talking about"*** and respondent D reported that ***"no the vomitting and induced diarrhea only occurs twice a week, on Wednesday and Saturday, those are the days of Instebenzelo"***, when asked if it occured on a daily basis. The purpose of the purgatives, emetics aswell as the medicinal bathing was to ward off evil spirits, strenghten them, decrease any presenting symptoms of the calling whilst increasing the Holy Spirit within them.

4.2.3.3. INtlahlubo (ability to divine)

Even though the respondents reported that their ability to divine is a gift given to them either by the ancestors or God, they all reported that they had to learn to harness it whilst in training through being actively involved diagnosing the problems of new patients. They all reported that they worked closely with their mentors and at times were given the lead role when a new person arrives. They reported that they had to diagnose the person through the "iNtlahlubo" technique in the presence of their mentor where both mentor and trainee had to come to the same conclusion about the exact nature of the person's life story without any prior communication among them.

Respondent A:

R: we were taught how to heal people, we prayed for people but under the supervision of our leader to ensure that we didn't make any mistake, there you should be able to divine what they divined without being told because all of you have the Holy Spirit in you

L: so you see people's problems spiritually?

R: yes, you see while we are busy praying for the person, we get visions about the type of pain the person is suffering from without having being told by the individual, after consultation with another faith healer who should also have seen the same vision, we tell

the person and find that they are in agreement that indeed they are suffering from what we have just said

Respondents also reported of having to accompany the faith healers to various households to watch the performance of rituals such as cleansings or ceremonies to appease the ancestors because they get sent to perform the same rituals alone as part of their practical training (Respondent D: …***we occasionally accompany him when he is going to perfom certain things in people's houses so as to see everything that he does, sometimes he lets us take the lead***...)

4.2.3.4. iSiwasho (Knowledge of different illnesses and medication to treat them)

All respondents reported of having been trained to identify various types of illnesses and their causes during the courseof their training. They reported that this they learn in part during the practical diagnostic training they have to do (iNhlahlubo). All respondent further reported that they have been taught on the different medication to use when treating various illnesses, medication which they all refer to as "Isiwasho". Respondent B explained that, ***"it's the medicines that we were taught to use when we were training, we divine and see which to use when dealing with different types of illnesses"***

The Trona, which all respondents reported to having gone through is what Peltzer (1999) referred to as immersion. This prominent feature of African Independent Churches refers to residing at the church premises on a full time basis for a lengthy period of time; and learning the trade of healing through consultation with the prophet (Peltzer, 1999). All respondents reported to have had to stay with their mentors, to consult with them on a daily basis and learn everything that there is to know about Faith healing. Even though power to heal is viewed as a gift or calling (except being an Herbalist) it must be cultivated through intense training and supervision (Vontress, 1991).

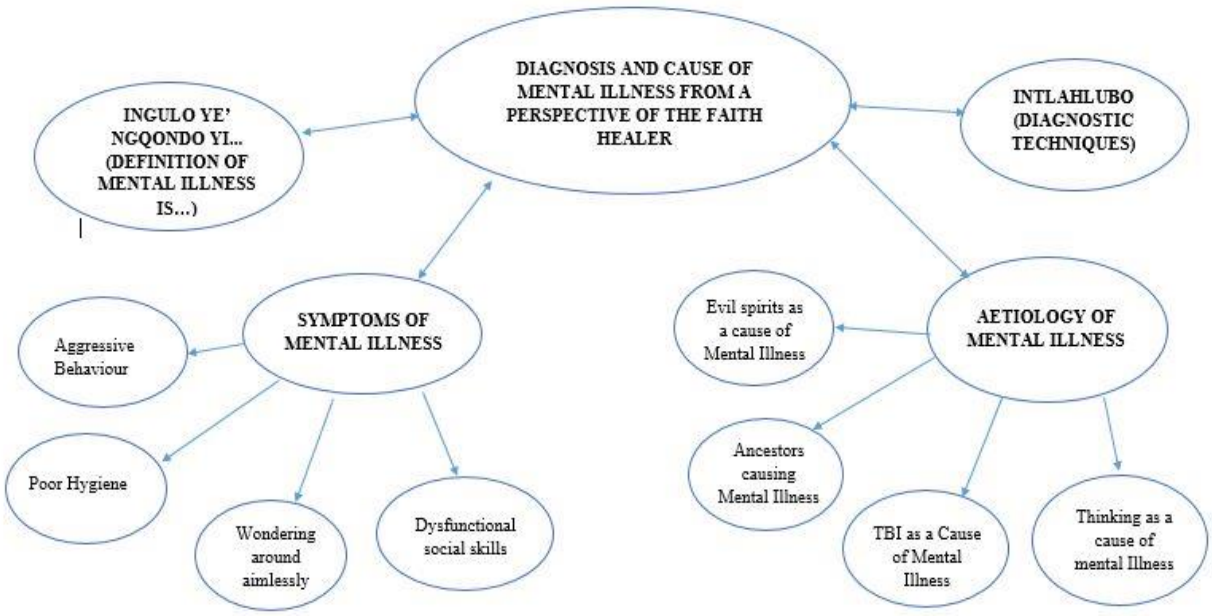
The similarities between Faith healing and traditional healing become evident again as Ross (2010) reported on a similar process for diviners, stating that by accepting the calling the individual moves from a neophyte via apprentice to a seasoned diviner. He further went on to state that the Faith healer is both called and trained in a similar manner as a Diviner, as stated earlier this is seen as a direct result of the rise of the African Independent Church (Ross,

2010). Allowing members to be Christian and African at the same time, has led to the rise of the African Independent Church (Meyer, 2004). No exact duration of years needed for training was stipulated by literature with Ross (2010) stating that it could take a number of years, Sorsdahl, Flisher, Wilson and Stein (2010) reporting that it could take only one year while Vontress (1991) reported that the duration of training varies pending on the intelligence and deposition of the student to learn with the average being a period of 9 years. The respondents however reported on a training period which lasted for 3 to 4 years. This then means that the duration of the training is at times dependant on the mentor who is teaching the new recruit and one can only leave the Trona at the approval of their mentor. One is only a Faith healer after gaining the necessary skills and after approval from the mentor. The exact features of the Trona which included daily church services, learning the ability to divine, and knowledge of different illnesses and treatment remedies fall in line with that reported by Vontress (1991).

4.3. Faith Healers Perspectives on the Diagnosis and Cause of Mental Illnesses

We now put focus on the respondents' account of the causes of mental illnesses. This section seeks to uncover the diagnostic tools that are employed by the Faith healers included in the sample during the completion of their healing duties. This section placed focus on the respondents' definitions of mental illness, diagnostic techniques employed by the respondents, what they viewed as the symptoms of mental illness and their perception of its aetiology.

Illustration 2: Cause and Diagnosis of Mental Illness through Faith Healing



Thematic Map 2: Cause and Diagnosis of Mental Illness through Faith Healing (Showing Four Main Themes, Their definition of Mental Illness (Ingulo Yengqondo Yi...), Symptoms of Mental illness and Aetiology of Mental Illness). Source: Authors' own creation

4.3.1. Ingulo Ye Ngqondo Yi. (Mental Illness is…)

When all respondents were asked to give account of their individual definitions of mental illness, all the definitions reported were based on what they viewed as symptoms of mental illness. None of the respondents interviewed provided a conceptual definition of mental illness but instead operationally defined it as according to the symptoms that they reported to have observed. This then means that the symptoms are the symbol of illness. The respondents' inability to offer conceptual definition of mental illness can be explained by Edwards (1986) who reported that unlike indigenous healers, western orientated health worker is trained in secular and empirical traditions. It is these traditions which have given them a conceptual and operationally defined nosology that acts as a guiding hallmark of their practice (Edwards, 1986).

Treatment options are only explored following a strict standardized guide (Diagnostic and Statistical Manual of Mental Disorders) across the entire field (Kaplan &Sadock, 2007). The lack of formalized training in indigenous healing makes developing a standardized nosology for indigenous healing a challenging prospect as the knowledge base differs from healer to healer. Ross (2010) substantiated the above statement when he reported that the training of

a new indigenous healer through apprentice is solely dependent on the transference of knowledge and skills possessed by the older healer to the trainee. One might then argue that this situation can lead to different knowledge bases for the treating of similar illnesses within the same category of indigenous healers. This being a direct result of not having a standardized nosology from which all Faith healers subscribe to, here knowledge acquired by the trainee is dependent on what the trainer knows.

4.3.2. INtlahlubo (Diagnostic Technique)

All respondents reported that unlike in traditional healing where the diagnosis is arrived at through throwing of bones, they arrive at their diagnosis by simply opening the bible and reading from it. They reported that traditional healers use what is called the "iMvumisa" technique where a person is made to blow in a bag containing bones, which then are thrown on the ground and that a person's problem is divined according to the arrangement in which they fall. Respondent C reported that "iNtlahlubo" technique is faith healer's version of the iMvumisa stating that ***"iNtlahlubo" is what is known in isiXhosa as the "iMvumisa"*** he further went on to say ***"iMvumisa" is the ability to speak someone's problems without having being told about them beforehand…that you are not taught as it just happens, as I have already mentioned before, God shows you all of that"***.

The respondents reported diagnosing illnesses by praying and randomly paging the bible, where the person's problems appear within the scripture. Respondent B gave the following explanation of the "iNtlahlubo" process:

R: Bible is in my hand as I pray, I'm wearing my full uniform then I give the bible to them and instruct them to put "isikhanyiso" /money inside it and then close. I then continue with prayer

L: Yes.

R: When I open it again I'll be able to see everything about their illness, it's as if it's all written in the bible..I then tell the person what I see, a process I told you is called "ukuhlahluba"

Unlike the western biomedical diagnosis and treatment process which follows a carefully predetermined procedure starting with identifying the problem "*with"* the patient (Kaplan &

Sadock, 2007), the account given by the respondents show the opposite. The INtlahlubo technique which is defined by Vontress (1991) as “Bibliomancy” requires little if any participation from the patient. While the western orientated health worker places focus on asking the patient about symptom content of their illnesses, the respondents accounts indicated that they are consulted with the contractual expectation that the diagnosis will be divined (Edwards, 1986). This opposing view between the two healing modes is further highlighted by Mzimkhulu and Simbayi (2006), who reported that patients of indigenous healers assume no personal responsibility. The roles are reversed as the patient assumes a passive role while the healer does all the work; whereas in psychotherapy the client actively works and the therapist takes a reactionary role (Mzimkhulu & Simbayi, 2006).

4.3.3. Symptoms of Mental Illness

All four respondents gave similar accounts of the symptoms of mental illnesses, with the focus of their understanding solely fixed on the behavioural dysfunction attributed to mental illnesses. The following symptoms were the reported by all four respondents.

4.3.3. Wondering around aimlessly

All respondents reported that they can tell that a person is mentally ill when they are constantly wandering around, going up and down without actually knowing where they are going. They reported that these people never really give a conclusive response when asked about where they are going but will instead give inappropriate responses such as swearing at you or even just totally ignoring you

Respondent D:

R: They go around picking up all the refuse thrown away by people, some wonder around not knowing where they are going

L: Yes.

R: The person has been walking up and down since the sun came up until it sets again without knowing where they are going...he needs to be tied with a rope so as to stay in one place

4.3.3.2. Aggresive behaviour

All respondents report that people who suffer from mental illnesses become very aggressive and at times with little or no provocation.

Respondent B

R:They are aggressive, they swear at you when you try to talk to them, others will even want to hit you.... its because they are always made fun off so they want to hit you even if you are trying to help them and they could seriously hurt you because they can use anything that they see to assualt you

4.3.3.3.Destructive behaviour

Respondents reported that people who are mentally ill have a tendency to destroy property as they do not have a sound appreciation of the "right thing" to do. They reported that one often finds them breaking windows, dishes, throwing away appliances that are still in working condition. This destructive behaviour is not only directed to their belongings but also the property of other people within the community.

Respondent A

R: They take working things like the Tv set, clothes and throw them outside, they like to break things, even my windows are not safe from a person who is ill, they see nothing wrong in throwing stones at them; then they just laugh at you

4.3.3.4. Poor hygiene

Respondents reported that those suffering from mental illness do not take an interest in their personal hygiene. They wear the same clothes until they are filthy dirty; they seldom wash so they have foul body odours. Respondents report that these people do not care for what they eat hence you find them going through refuse bins, eating whatever they find, hording things that have been thrown away by other people and even sleeping in those dumping sites (Respondent D: ***"Yho (exclaims)...they are dirty, they do not wash, its like months past and the person is still wearing the same thing, some you find eating from the bin"***.

4.3.3.5. Dysfunctional social skills

The respondents reported that people who suffer from mental illnesses show dysfunctional social skills, where you find that sometimes the individual's communication skills have been affected. They report that such individuals isolate themselves, refusing to speak to even when asked questions and even if they do respond one finds that the responses are irrelevant to questions posed. Respondents report that such individuals have a tendency to talk to themselves as if engaged in a conversation with someone/something that other people can't see. Inappropriate laughing and murmuring have also been reported (Respondent C: ***"Completely silent, even when you call, they're silent, and when they do respond they just start swearing...you hear me, some are always smiling, constantly smiling, they laugh at things you can't see"***)

Even though differences were noted between the two healing modes (western psychiatry vs. indigenous healing) with regards to the diagnostic techniques they each employ, it appears that the two modes share the same understanding of symptomology. The main themed symptoms reported by the respondents are in line with those included in the strict guide (Diagnostic and Statistical Manual of Mental Disorders) reported on by Kaplan and Sadock (2007). It is however important to note that all symptoms reported by the respondents are those that indicate overt social and behavioural dysfunction. This then brings into question their knowledge of the subtle intricate symptoms of mental illnesses. Furthermore, their understanding of symptoms focused only on what one might term as a psychotic episode, this again raises the question over the extent of their knowledge of other mental illnesses where the psychotic episode is not the prominent feature.

4.3.4. Faith Healer's Perception of the Aetiology of Mental Illness

The causal attributions for mental illnesses in Faith healing can be grouped into four main sub-themes. These sub-themes make up the most common explanatory models collected from the raw data collected from the respondents' and are said to be the ones responsible for the mental illnesses treated by the respondents in their healing practices. The respondents reported that most if not all, causes of mental illness can be attributed to evil spirits, punishment from the ancestors, traumatic brain injury and over thinking.

4.3.4.1. Mental illness caused by Evil spirits

All respondents report that evil spirits are one of the main factors that cause mental illnesses. They report that sorcery and witchcraft form the basis of these types of mental illnesses. Here potions with agents made to cause mental illnesses are mixed with the food and water we drink resulting in the intended illness after consumption. The respondents' reported that people, motivated by make use of such potions or herbs which they get from other indigenous healers to intentionally cause a person to develop a mental illness.

Respondent A

R: In that case you have been fed "idliso" by another person because they are jealous of you, that "idliso" then cause you to go crazy

L: And you become mentally ill?

R: Yes, because that demon you have been fed is working on you

The respondents further note that one can become mentally ill if he/she saw something that they weren't supposed to see. In this regard they report that seeing the mystical creatures and agents used for witchcraft will result in mental illness because the owner of that creature intentionally causes the person to be mentally ill in an effort to prevent them from disclosing or describing what they have seen.

Respondent C

R: So it happens that you see something that you weren't meant to see, something that is a bad omen. Evil spirits are real, whether you like it or not, you might see a big toad, there's a very big toad or "mamlambho" mermaid.

L: Yho! (exclaims)

R: When you see it you get frightened so much that your eyes roll back, you fall and start having seizures, after those seizures have past you start being mentally ill.

L: Yho! (exclaims)

R: Because what you saw is not meant to be described to others

Lastly recurrent seizures are also seen as illness which is intentionally caused as people have been fed "ifufunyane" (agent of witchcraft) so as to disrupt their lives. They report that these

seizures will time develop into mental illness with the accompanying symptoms described above.

4.3.4.2. Mental illnesses caused by the ancestors

All respondents report that mental illnesses are in many cases inflicted on people as punishment from their ancestors.

Respondent A

L: So you're saying you cannot heal a person if their ancestors are not in agreement?

R: I can't, you need to first show the ancestors respect, if you do not care for them, and then they will cause you to suffer by giving you a mental illness

The respondents' reported that one needs to constantly respect his or her ancestors, they reported that if the ancestors turn their backs on a person and withdraw their protection then the likelihood is that one will develop a mental illness. The respondents further reported that failure to do certain cultural ritual sacrifices for the ancestors, or failure to acknowledge gifts bestowed on you by them (e.g. calling to be a healer) leads to punishment in the form of a mental illness. Furthermore, failure to follow ritual sacrifices in the exact manner which has been prescribed by the ancestors without first appealing and appeasing them will also result in you getting punished with a mental illness. Respondents reported that failure to acknowledge the ancestors as supreme beings with governance over us results in them showing their wrath on the person, which in most cases is by causing great misfortune, physical and mental illnesses

Respondent D

R:Mayb,e they want you to slaughter a cow for them, or want you to do a certain ritual...then it is important that you do as they tell you because if you do not do as you are told...yho! haike, (exclaims) they will punish you by taking your brain and making you mentally ill, you mustn't stop doing rituals if you are a person that does so

L: Yho! (exclaims) they take away your brain?

R: You don't mess with the ancestors...if they want something from you now, do it or if you do not have the means to do it then you need to brew alcohol...plead to them...that you heard them but that you do not have money to do what they ask of you, don't just keep quiet as if you do not care for them

L: Yes.

R: They do not play around, you will have a severe mental illnes because of them

4.3.4.3. Mental illness caused by a traumatic brain injury

Three (A, C &D) of the four respondents reported that mental illness can be a result of physical injury that has caused damage to the brain resulting in the person developing a mental illness. They reported that things like having a car accident or a severe blow to the head during stick fighting can lead to a person developing a mental illness because "the blood in the head has now mixed with the brain". They further reported that this could also happen if certain veins or nerves in the brain get affected as a result of the accident, restricted blood flow to the brain. Respondent A and C are of the view that mental illnesses caused by traumatic injuries to the brain can only be healed by hospital doctors and not spiritual doctors with respondent C reporting that ***"…so I can't help a person like that, that person needs a doctor"***. Respondent D also shared similar sentiments stating that there's nothing that they can do unless if you were hit with a "storom" (meaning that the stick you were hit with was laced with muthi that one obtained from a traditional healer).

4.3.4.4*. Mental illness caused by over thinking*

Two of the respondents (B & C) reported that they also attribute mental illnesses to over thinking, stating that if a person is constantly thinking about negative things then they can get mentally ill. They reported that the person's life problems or their socio-economic situation can be so dire that it causes them to be mentally ill.

The respondents' appreciation of the aetiology of mental illnesses is embedded within the indigenous framework. Campbell-Hall et al. (2010) supported this view stating that care offered by indigenous healers is linked to indigenous explanatory models which incorporate the spiritual correlation of illness and the understanding of the individual interpretation of

illness in relation to its causation. The respondents' perception that ancestors and evil spirits are the most common causes of mental illnesses is a prime example of indigenous explanatory systems. The respondents' explanatory model accepts Ngubane's indigenous classification system, which reported on three broad categories namely Magical, Animistic and Mystical causes of mental illnesses (Edwards et al., 1983).

Their appreciation of the role played by the ancestors in the causation of illness was referred to by Ngubane as Animistic causation; illness resulting from the behaviour of a personalized supernatural agent, such as a spirit or God (Edwards et al., 1983). Angering the ancestors through behaviours such as failure to perform cultural rituals or refusing to accept and acknowledge gifts bestowed on you by them is seen by the respondents as the leading cause of illness.

Sorsdahl et al., (2010) supported this view reporting on a belief that the gift of a calling is at times accompanied by a normal creative illness before spirit possession; however, failure to accept the calling results in a permanent mental illness. The view is that the presenting symptomology of mental illness (psychotic episode) is not diagnosed as such but rather as the normal temporal process of receiving divine powers. The respondents' appreciation of the role played by the evil spirits in the causation of illness was referred to by Ngubane's classification as Magical causation; attributing illness to the covert actions of a malicious person who employs magical means to cause harm to victims (Edwards et al., 1983). Examples provided by the respondents included that of witchcraft or coming into contact with agents of witchcraft that one should never be in contact with. Makhanya (2012) substantiated their view, reporting of a hysterical condition characterised by speaking in an eccentric muffled voice, in a language that cannot be understood, violent behaviour and psychomotor agitation. This condition is believed to have been caused by sorcery (Makhanya, 2012).

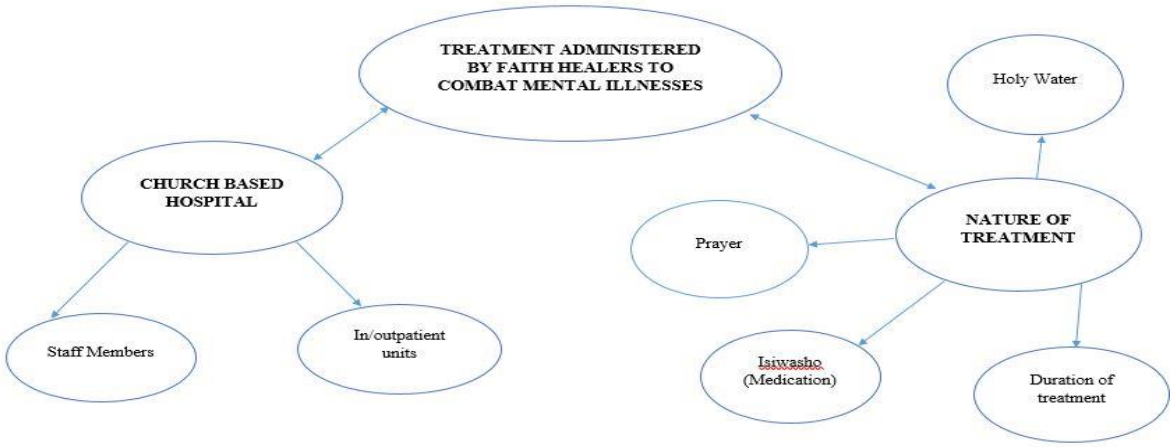
The other two reported causes of mental illness are ones which the respondents reported to not being able to treat. All respondents reported limits to their abilities, stating that they could not treat mental illnesses which they view to be a result of a Biological cause. Mental illnesses resulting from traumatic brain injury are seen as out of their jurisdiction and can only be attended to by hospital doctors. Ross (2010) substantiated the issue stating that whereas the western biomedical model attributes illness responsibility and agency within the

individual, the opposite is true with indigenous healing where the focus of causation is on external forces. Furthermore, the lack of depth in respondents' views on "overthinking" also being a cause of mental illness reaffirms question over the depth of their understanding of mental illnesses which do not present with overt behavioural dysfunction.

4.4. Treatment Administered by Faith Healers to Combat Mental Illnesses

The following theme looks at the treatment administered by faith healers in their combat of mental illnesses. This section focuses on two main sub-themes, namely the physical church premises operation as an indigenous hospital and the exact nature of the treatment regime employed by Faith healers.

Illustration 3: Treatment Administered by Faith Healers to Combat Mental Illness



Thematic Map 3: Treatment administered by Faith Healers to Combat Mental Illness (Showing two main themes: The Church Based Hospital and Nature of Treatment). Source: Authors' own creation.

4.4.1. Church Based Hospital

All four respondents reported to using their church bases as the equivalent of western orientated hospitals. All respondents reported on admitting people to stay with them while receiving treatment for multiple illnesses including mental illnesses. They reported that not only did they admit people to stay with them for the duration of their treatment but also reported on running out-patient services where those suffering from minor ailments come to collect their medication. All four church bases had multiple dwellings that served different purposes for each Faith healer and others residing there (refer to observation).

4.4.1.1. *Staff members*

All respondents reported to having people that assist them in the completion of their duties. As bishops in their respective churches, they utilize the members of their church congregation as the workforce they need to carry out their healing tasks. They report that being part of the church congregation directly implies that one has the responsibility to go and assist the Faith healer in all aspects of his or her work (Respondent A: ***they were members of my church congregation, people who come worship here also work here, they have to know that my patients need to wash, eat so they used to come to boil the water, others took care of new patients upon their arrival, they are the ones responsible for "ukuhlahluba" in my absence, others guarded the sick from escaping and they also feed them"***).

4.4.1.2. In and out patient units

As previously mentioned, all respondents reported to both having patients that they admitted to their churches as in patients as well as those who were out patients and only came to on certain days to for the further management of their illnesses. None of the respondents could give the exact number of people who have consulted them with mental illness related issues. As a result, all respondents were asked to give an estimate number of mental illness related cases that they had consulted on over the duration of their healing. Respondent B, the most experienced in faith healing estimated having consulted with more than 200 people with mental illness related issues. Two of the respondents (A & D) estimated that they had consulted on more than 100 cases respectively while Respondent C gave the lowest estimate of less than 50 cases.

The in-patient intake capacity for people with mental illnesses, varied across all four church hospitals. The highest number (15) of people was reported by Respondent B while the lowest number (8) of people was reported by Respondent C. Respondent A, who reported 10 people and Respondent D (13) formed the median range

4.4.2. Nature of Treatment

The exact nature of the treatment options utilized by the respondents in the study highlighted three main tools used in their healing work namely holy water, prayer and iSiwasho (their form of medication) The duration of treatment was also highlighted. Three of the four

respondents (A, B& D) reported to using Holy water, prayer and iSiwasho to heal those individuals who suffer from mental illnesses. Respondent C denied the use of any type or form of iSiwasho for healing purposes.

4.4.2.1. Holy water

All respondents stated that *holy water* is clean water which they get from the tap, with the only difference being that it has been prayed for by the respondents to grant it the power to heal.

Respondent B

L: what type of water is that, what's in it?

R: nothing is in them, you too can drink from them, I get them from the tap but it's just that it is water which I constantly pray for, hence their healing power.

They reported that drinking this water multiple times a day will lead to a reduction of presenting symptoms. The respondents claimed that many people who suffered from mental illnesses have been healed just by drinking the water for the duration of their stay at the faith healers house.

4.4.2.2. Prayer

All respondents reported that the corner stone of their practice is *prayer*. They reported that the laying of hands on the sick individual while praying for them has also been reported to be the main aspect of treatment.

4.4.2.3. iSiwasho

Three of respondents reported the use of "isiwatcho" which is used for purgative, emetic purposes twice a Week on Wednesdays and Saturdays. Respondent D defines isiwatcho as ***" that is given to us by our faith healer, the same ones that he teaches us about, which to use to heal certain things or how to mix them"***.Furthermore all three respondents reported that it is in a powder form which they mix to make various medicated mixutes which are given to those under their care to drink.

Even though respondent C shared the same account with reference to the use of holy water and prayer in his treatment regime he denied the use of any "isiwatcho" stating "***no I know nothing of iSiwasho, I do not even know what they are***". He reported that the only treatment he uses, even for purgative and emetic purposes, revolves around prayer and holy water.

4.4.2.4. Duration of treatment

Three of the respondents (B, C &D) reported that the duration of their treatments range from a period of six months to a year while Respondent A reported that his gift allowed him a treatment period of only two months.

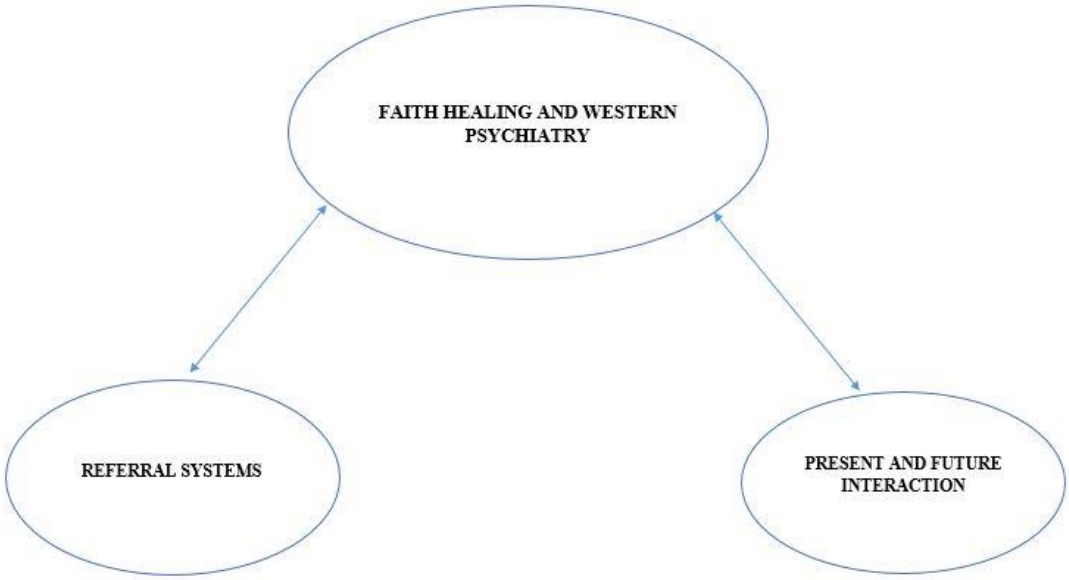
The respondents accounted on the extent of healing practices in their churches and such focus was placed on healing that the church resembled a hospital. Respondent B, at one point referred to her church as a garage where people came to fix their bodies. However, the magnitude of focus they placed on healing is not misplaced. Schoffeleers (1991) reported this focus as the defining feature of African Independent Church Movement (to which all respondents belong), defining them as churches which regard healing to as important as the doctrine, pastoral praxis and the recruitment of new members. One can even argue that the interpretation of the doctrine, pastoral praxis and recruitment of new members are all focused on the healing aspects of the church. This argument is not only supported by the respondents through accounting on their healing duties but also by Peltzer (1999) who reported that healing in these churches happens in three main stages. Healing is reported to take place during church services, through staying on the church premises for lengthy periods of time and the constant interaction with the prophet (Peltzer, 1999). The idea of a "the church hospital" was coined by Daneel (1970) after first visiting an Independent Church in the then Rhodesia. The church site has multiple huts for new arrivals, where the sick stay throughout the duration of their healing (Daneel, 1970). The experience shared by Daneel supports the accounts given by the respondents who also reported that their church sites have multiple dwellings that are reserved for accommodating the sick, just as is the case in western orientated hospitals. The respondents reported that they received help from members of their congregation in the day to day running of the hospital. Bate (2001) added to this view, reporting of a system of mutual aid and help (receiving treatment not only makes you financially liable to the faith healer but the recuperating patient has to work for them).

Makhanya (2012) substantiated the treatment methods reported by the respondents stating that Faith healers heal through a combination of herbs, Holy water, payer, the laying of hands and at times requiring the individuals to reside with them for a period up to a year. However it should be noted that unlike the strictly regulated western biomedical models of treating mental illnesses, indigenous treatments differ according to the healer's training and healing method (Campbell-Hall et al., 2010).

4.5. Faith Healing and Western Psychiatry

The last section of the results and discussion places focus on the relationship between the respondents in the study and Western Psychiatry. This section covers two main aspects, namely referral systems and interaction with Western trained doctors.

Illustration 4: Faith Healing and Western Psychiatry



Thematic Map 4: Faith Healing and Western Psychiatry (showing two main themes: Referral Systems and Present and Future Interaction). Source: Author's own creation.

4.5.1. Referral Systems

All four respondents reported that minimal formal interaction with Western trained doctors, stating that the only interaction that occurs is when a patient that they are treating has to go and collect medication from the hospital. They all reported that they are not against the combined use of their brand of medication and that which is given by doctors at the hospital.

Respondent A

R: If they are on treatment that is prescribed by the doctor then I should make sure that my medication is not stronger than the one they are currently on so that both treatments work. Both treatments should try to fix the situation, what the doctor saw will not change without the treatment and that the person needs to take the treatment for life. Sometimes a person who stops taking their treatment dies and then people say that you cannot heal

They reported that they have never discouraged the use of hospital medication but that the only medication that they do not allow a person to take is that of a traditional healer.

4.5.2. Present and Future interactions

Two of the respondents (A& C) reported that they indeed do see a need for faith healers to be placed in hospital settings, stating that they would play a huge role in praying for those that need it. They reported that they would complement the work done by doctors, follow behind them and pick up on things that do not appear on the machines that they use. The two reported that this would allow them the right to sign out a patient and take them home where they would use their brand of healing should western means offer no help.

Respondents B and D shared the opposite notion, stating that things are fine as they are. They reported that they would be belittled in a hospital setting. They reported that the doctors would always second-guess them and would never really see them as equals.

Even though no current formal referral systems are in place between the two healing modes, the respondents' attitude towards western orientated treatment appears to be positive. This situation can only be for the benefit of the patient. It is however interesting to note that their attitude towards treatment obtained from other categories of indigenous healers appears to be opposite, especially that of traditional healers. This attitude further highlights the growing animosity between the two healing modes, as discussed in previous sections. Even though the respondents show a positive attitude towards the dual use of treatment with western orientated healing, an area of concern arises over the type of interaction this treatment might have on the patient. Makhanya (2012) makes note of this issue reporting that South Africa is trying to regulate the treatment practices of indigenous healers in an effort to ensure that the rights of the patient are not abused. This view is one that is concerned with the basic human rights of the individual under indigenous care.

Treatment options and facilities should at all times preserve the patient, especially the mentally ill patient, his or her right to dignity. It has become increasingly important to understand the nature of properties in the medicinal mixtures given to patients so as to rule out any negative interaction between the treatments of both views (indigenous vs. western). Ross (2010) substantiated this view, reporting a South African context where 80% of health service users use both systems concurrently while further emphasising the need for collaboration between the two especially with regards to the treatment of severe mental illnesses where adherence from a biological perspective is paramount. However not all respondents are of the view that such collaboration is beneficial for them.

Half of the sample felt that there was no need for any collaboration but that things should remain as they are. The respondents anticipate that they would be belittled in such collaboration, where they would never be seen as equals by their western trained counter parts. Campbell-Hall et al. (2010) reported on this concern stating that collaboration is not ideal to some indigenous healers as they are concerned that they may be exploited for their knowledge and skills, or be viewed as having nothing to offer the health services because they lack formal medical training. Wreford (2005) also shared the same view, stating that indigenous healers' perceived lack of knowledge of the biological aspects of mental illness would make such collaboration very challenging.

Chapter 5: Conclusion

5.0. Introduction

The focus of this chapter is to summarise the all findings of the study. It reviews the main views collected from the themes. The function of this is to clearly illustrate the success of the study in its attempt to answer all research questions. Secondly, this chapter informs of the prospective research areas that arose after having concluded on the results and discussion chapter. Lastly, it gives insight on the researcher's subjective experience of the process.

5.1. Conclusion

After having reviewed literature around indigenous healing practices, it became clear that Faith healing had not been afforded the same study opportunities as other indigenous healing systems. It was this view that intrigued the researcher, prompting him to embark on a study that would put focus on faith healing as an indigenous system of healing. The aim of this study was to get insight on Faith healers perspectives on the diagnosis and treatment of mental illnesses, in an attempt to fill the gap in existing literature gathered from other categories of indigenous healers. Even though not a comparative study at the core, the aim of the study enabled discourse not only about the generated new knowledge, but also on the differences and similarities that arose between all categories of indigenous healing systems. This discussion allowed the researcher, who has been trained in the western orientated view of psychiatry an opportunity to immerse himself in a different view point to psychiatry.

The researcher feels that the aim of the study has been successfully achieved, owing to the respondents' willingness to engage and share their knowledge of Faith healing practices. Their engagement allowed for a rich detailed enquiry from which the following research questions were explored in-depth:

- How do self- identified Faith healers describe their training and preparation to become Faith healers?

From this the researcher learnt that, as in the case with traditional healers, the journey into Faith healing is one that is initiated through a calling. Unlike herbalists who personally choose to embark on the journey to studying indigenous healing techniques (as is the case with western trained health professionals), Faith healers are instructed to embark on their journey.

This calling, which is said to come from either God or the ancestors manifest through dreams, visions or physical illness and is said to stop after accepting the call. The training, which the respondents' referred to as the period of "Trona", requires the individual to stay with a seasoned Faith healer for up to four years. It is during this period that they learn all intricacies of Faith healing via apprentice.

- How do self-identified Faith healers understand the causes of mental illnesses?

This question brought about indigenous views to the causes of mental illnesses. From this we learned of the role played by the spirit realm in the causation of mental illnesses. Unlike the western view which explains illness from a biomedical viewpoint, the Faith healers in the study attributed the majority of mental illnesses to evil spirits and the ancestors.

- How do self-identified Faith healers understand the treatment options for mental illnesses?

Here, the discussion centred on the tools used by Faith healers in the combat of mental illnesses. From which we learnt that the treatment options used were prayer, holy water and their brand of medication known as **iSiwasho**. The Faith healers included in the sample reported that the laying of hands while praying for the patient, constant drinking of holy water and consuming mixtures of **iSiwasho** for purgative and emetic purposes was the methods used in the treatment of mental illness.

- How do self-identified Faith healers collaborate with the medical model of understanding mental illnesses?

It was established that no formal collaboration occurred between the two world views, with the only contact occurring when their patients needed to go fetch treatment from the hospital. The lack of collaboration was viewed as good by other while others welcomed the idea of future engagements.

5.2. Limitations and recommendations of the Study

Just as is the case with all research studies, limitations arose that hampered the (to a degree) the research process. The first of these limitations was the limited number of self-identifying Faith healers within the demarcated research area. This was a direct consequence of the view

that Faith healing is thought to be a gift that only a few people possess. However, this was combated by choosing a small sample size that would be able to give rich detail of the study area. However, this meant that the finding of the study cannot be generalized to the entire population but to that of the Faith healing techniques of the Chris Hani district. This scenario has therefore created an area for the further investigation of, Faith healing practices in other provinces of South Africa. Conducting such studies would enable scholars to generalize findings for Faith healing practices in South Africa, where we are able to compare and contrast our findings with the hopes of gaining a clear view of this indigenous method of healing.

The role played by spoken language vs. academic language also posed as a limitation to the study. All research respondents included in the study, the researcher, all use isiXhosa as their home language. On the one side, this created effective communication with the respondents during the data collection phase, where all parties involved were able to express themselves freely thus, allowing for rich descriptions of phenomena. The limiting aspect of this appeared during the translations, where the academic language (English) was utilized. Unlike the English language, with its many descriptive words, the researcher found that in isiXhosa, a single term can be used to describe multiple and different phenomena. So the translation of data from one language to another (with differing language rules), created an environment for some descriptions to be lost in translation.

Thirdly, it was noted that even though respondents had some appreciation of the symptoms of mental illnesses, the depth of their appreciation was a cause for concern. Their appreciation of the entirety of mental illnesses is purely based on overt social and behavioural dysfunction which the western orientated health worker would call a psychotic episode. It would be useful to establish the depth of their knowledge of other mental illnesses which do not necessarily present with a psychotic episode. This was also viewed to be an area for further investigation.

Lastly, the success of treatment options provided by the Faith healers in the study also present as an area for further investigation. Whereas the western orientated approach to psychiatry offered multiple treatment options for mental illnesses (different pharmacological and psychotherapeutic strategies for different mental illnesses), the respondents' mechanism of healing hasn't been articulated clearly. This could then be further investigated through

research that focuses on “the experience of patients who have consulted both, Faith healers and western psychiatry”.

5.3. Reflective Commentary

Embarking on this study has both been the most rewarding and challenging aspect of my academic life to date. It has offered me the chance not only to hone my skills as a novice researcher but also provided personal growth and understanding of different walks of life. Research has never been my strong point; my main focus was and still is “the Clinical practice”. However, one might argue that to truly be a Clinician, one must actively be involved in the generation of new knowledge and this principle encouraged me, even when the task at hand appeared too daunting. The minimal experience gained from completing my Undergraduate research project could never have prepared me for the reality of the task I was embarking on. The quality of work required at this level, left one feeling like a “fish out of water”. However, through perseverance and celebrating the small victories along the way, I look back at a process that is at its completion with pride.

My identity is a motivating factor for the present study. I am a black isiXhosa speaking South African from the Eastern Cape Province, I am a product of a worldview that not only acknowledges but also participates in cultural rituals. I am product of an ethnic background which appreciates the existence of deities which offer protection and guidance in our lives. My “acknowledgement” section offers proof of this, not only did I acknowledge “God’s” grace but also recited my clan names. Reciting one’s clan names is a manner of paying homage to their lineage and their Ancestors, however, I am also a product of the Western worldview. I am a Clinician, a scientist schooled in a worldview opposite to that of my upbringing. So the questions that plague me are:

- How does one navigate the waters of these two opposing worldviews?
- Can science, religion and superstitions coexist in clinical work even though differing in worldviews?

There is a tendency of assuming that both religion and superstition are the opposites of science but is that entirely true? Or can one argue that they share similar characteristics, in that all three seek to explain the world? One would assume that they have been parallel to

each other because most people operate from one, unfortunately I find myself influenced by all three, hence the struggle and motivation in searching of answers to these questions.

Being influenced by all three worldviews provided advantages during data collection in that the terminology used by the respondents was familiar to me however, the opposite was also true. My preconceived ideas threatened to hamper the data collection process as I found myself wanting to lead the interview. I constantly had to remind myself that, I was not the "expect", that I was facilitating rather than directing and most importantly, that I was there to learn, not to teach. Even though this study provided many challenges for me, the knowledge gained has been invaluable. Although, I still find myself stuck in not knowing how to truly navigate between worldviews. A question which I hope will be answered through future studies on the matter.

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Annexure 1: Ethical Clearance Certificate

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RESEARCH PROJECTS AND ETHICS REVIEW COMMITTEE

16 February 2017

Mr Liso Tsotsi and Mr Jan Knoetze
Department of Psychology
RHODES UNIVERSITY
6140

Dear Liso and Jan

ETHICAL CLEARANCE OF PROJECT PSY2017/05

This letter confirms your research proposal and ethics protocol with tracking number PSY2017/05 and title, 'An explorative study into faith healing as an African belief system and its influence on the diagnosis and treatment of mental illness in the Eastern Cape, South Africa', served at the Research Projects and Ethics Review Committee (RPERC) of the Psychology Department of Rhodes University on 25 January 2017. The protocol was accepted with stipulations. The Committee is satisfied that the required amendments to the proposal and protocol have been effected and you are hereby granted ethical clearance to proceed.

Please ensure that the RPERC is notified should any substantive change(s) be made, for whatever reason, during the research process. This includes changes in investigators.

Yours sincerely

Mr. Werner Bohmke
CHAIRPERSON: RPERC

Annexure 2: Information Document/Consent Letter

PSYCHOLOGY DEPARTMENT

INFORMATION DOCUMENT

This letter seeks to inform you as potential respondents about the nature and purpose of the study which you are being asked to be a part of. This study seeks to gain insight into the workings of indigenous healing, with specific focus on Faith Healing as a healing method which combats mental illnesses. The study seeks to understand how you as faith healers contextualize mental illnesses, with an interest in the following five main aspects of your healing practises

The nature and duration of training required to be a Faith Healer

What constitutes symptoms of mental illness?

What are the causal factors of these types of illness?

How you as Faith Healers treat mental illness

Whether or not you require collaboration with Western Orientated Healing methods

As a potential respondent, you have the right not to agree to be part of the study or can opt to end the interview at any point, should you feel that the questions being asked make you uncomfortable.

Should you agree to take part:

Data will be collected using interviews which will be conducted in your preferred language and all information collected will only be used for research purposes only. Furthermore, your identity will be kept secret through the use of a pseudonym/false name so as to ensure that no one can connect you to the information you have provided. The data which will be

collected during the interview will be recorded using an audio recorder, transcribed and translated to English.

The aim of this study is not to falsify your Healing practises or to judge them but rather to gain insight for future collaboration with other healing methods. The conclusions drawn will not seek to put you in a bad light but will be drawn from the information that you provide.

You are encouraged to clarify any concerns you may have about your participation or consequences you may experience as a result of participation in the research, by contacting either the researcher or supervisor using the contact details below:

Principal Researcher: Liso Tsotsi

Telephone Number: 0721136158

Supervisor: Jan Knoetze, RU Psychology Department

Telephone Number: 0466038344

Please sign below if you consent to be part of the study

Date:

This research study was approved by the Rhodes University Research Ethics Review Committee.

Annexure 3: Interview Schedule

PSYCHOLOGY DEPARTMENT

Interview Schedule

AN EXPLORATIVE STUDY INTO FAITH HEALING AS AN AFRICAN BELIEF SYSTEM AND ITS INFLUENCE ON THE DIAGNOSIS AND TREATMENT OF MENTAL ILLNESS IN THE EASTERN CAPE PROVINCE, SOUTH AFRICA.

1.0 Demographic Data

1.1 Gender:

1.2 Religious affiliation:

1.3 Level of Education:

1.4 Number of years practising as a Faith healer:

2.0 The nature and the duration of training needed to become a Faith healer

2.1 How would you define/describe the practise of Faith Healing?

2.2 How is the practise of Faith healing different from other healing; methods both Western orientated and other traditional healing systems?

2.3 Does Faith healing have any common entities with the other above mentioned healing systems? if yes please specify

2.4 What motivated you into becoming a Faith healer

2.5 Are there other Faith healers in your family (past or present) or are you the first?

2.6 Would you say Faith healing is a calling or a chosen profession? Give reasons for your answer

2.7 Is there a formal school for learning to be a Faith healer or one finds a more experienced healer to teach them?

2.8 How do you go about finding a teacher to teach you in the trade of Faith healing?

2.9 Are there different levels/categories amongst Faith healers?

2.10 Please explain in detail the process/training involved in becoming a Faith healer

2.10.1 What is the duration of training?

2.10.2 How much is the cost of training?

2.10.3 What marks the end or graduation as a faith healer?

3.0 **What constitutes symptoms of Mental Illness?**

3.1 How would you define mental illness?

3.2 Are the different types of mental illnesses?

3.3 If yes to question 3.2 what are the different categories that you use to classify them?

3.4 Are these categories different to other traditional healing systems, if so how?

3.5 What are the main symptoms of mental illness (things that alert you that a person isn't mentally well)?

4.0 Treatment offered to those under their care

4.1 Do any of the people you treat stay on your compound (equivalent of an admission into a psychiatric hospital)?

4.2 If yes to question 4.1, then how many currently reside with you?

4.2.1 How many can you accommodate before reaching full capacity?

4.2.2 Do you have other people who help you manage those under your care? If yes, then how many people do you have?

4.2.3 Who trains your other staff members?

4.2.4 Do they have specific titles?

4.2.5 What are their roles?

4.3 Please give a detailed account of the types of treatments you offer for the various illnesses you have encountered as a Faith healer/

4.4 What is the average duration of treatment?

4.4.1 Is the treatment once off or continuous?

4.4.2 What informs you that the treatment has been successful?

4.4.3 What happens when it doesn't work, do you refer to other Faith healers, Traditional healers or even medical doctors?

4.5 What is the average cost of treatment?

5.0 <u>Collaboration with Western orientated school of thought</u>

5.1 Are you for or against the use of mental hospitals in the combat of Mental illnesses? Please give reasons for your answer

5.2 Have you ever worked in conjunction with Western trained doctors in your combat of mental illness?

5.2.1 How has this interaction with them been?

5.2.2 Do you wish to have any future collaboration with these Western trained doctors? How would such collaboration look?

5.2.3 What is your take on the combined use of both Traditional and Western prescribed medicine by the patients you treat?

5.3 Do you feel that there is a need for traditional healers such as yourself to be employed in Western orientated mental health hospitals?

5.4 What would your role be in such settings?

All questions were structured to avoid any technical jargon so as to ensure that all respondents understand what has been asked of them. Furthermore, it is worth noting that the nature of the interviews may lead to the spontaneous development of more questions not included within the interview schedule.