Mental illness and Black South African culture: Exploring experiences and meanings attached to schizophrenia

By

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Declaration of Authorship

I hereby declare that this thesis is my own work and, to the best of my knowledge, contains no material previously written by another person except where due acknowledgement is made. This thesis has not been submitted for any other degree or diploma at a University or an institution of higher learning.

Date: ....................................................

Signature: .............................................
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My mother, for being such an amazing support system throughout my life and for making me who I am. *Ke a leboga Kgabo.*
Dedication

Philemon Molefe Monama

1943-03-31 to 2010-03-30

My dearest father, may your soul rest in peace. Thanks for being my parent and for teaching me humility. Mokone wa ‘Nishi Dikgolo.
The better path I gaze at and approve,

The worse – I follow.

Poet Quoted by Benedict de Spinoza, The Ethics (1677) Translated by

R.H.M Elwes
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Summary

Schizophrenia is one of the most-researched illnesses, and there is huge body of knowledge available that attempts to describe the illness, its causes and its treatment. Over a period of centuries, advances have been made regarding the illness. People with psychotic mental illnesses used to be burnt at the stake because they were deemed to be possessed by evil spirits. The medical model claims that schizophrenia is caused by a range of anomalies, from imbalances in neuro-transmitters to defective genes. Traditional Black South African beliefs state that ancestral dissatisfaction could be responsible for psychotic mental illnesses. The story of six blind men who were asked to describe an elephant using only the tactile information at their disposal captures the essence of the schizophrenia puzzle. Each blind person described the elephant from his own point of view.

This study seeks to explore how Black South African patients who have been diagnosed with schizophrenia, together with their family members, experience the illness from their cultural point of view. The theoretical framework underpinning this thesis is hermeneutic phenomenology. Three patients, each with a significant family member, took part in the study. Unstructured questions were used and the narratives were analysed thematically. The findings of this thesis revealed that, even though participants complied with the medical treatment of schizophrenia, their cultural and religious backgrounds informed the way in which they made sense of the illness during its earlier phases. This thesis proposes that mental health care workers need to be aware of the everyday taken-for-granted experiences of patients who have been diagnosed with schizophrenia. They also have to be aware and respectful of the cultural and religious beliefs that these patients and their families bring into the therapeutic spaces. Connectedness of these families with others needs to be
encouraged, as it seemed to lessen the stigma that is attached to schizophrenia, and being connected also assisted in reducing the carer burden that was experienced by the carers.
Chapter 1

If you talk to God, you are praying; if God talks to you, you have schizophrenia. If the dead talk to you, you are a spiritualist; if you talk to the dead, you are schizophrenic.

Thomas Szasz: Schizophrenia

Background

Schizophrenia is described by Andreasen (1997) as a complex and puzzling disease because it is characterised by a multiplicity of symptoms affecting most aspects of human cognition, emotion and behaviour. Patients may experience abnormal perceptions such as auditory hallucinations, subjectively feel that their thoughts and emotions have been taken from them, or believe that their ideas, feelings and movements are under the influence of some malevolent outside force.

Thakker and Ward (1998) further explain that the inclusion of the cultural framework in the DSM-IV provided potential benefits in clinical assessment. One of the primary advantages is the greater capacity for understanding the patient and his or her situation. The other benefit of the cultural formulation is the enhancement of the patient-clinician relationship; if the client feels that his or her beliefs, values, and practices are understood and respected by the clinician, then there is an increased likelihood that good rapport will be established and the patient will trust the clinician and his or her clinical procedures (Thakker & Ward, 1998).

Castillo (1997) argues that the changes in the DSM-IV, especially the introduction of cultural factors, are an expansion beyond the traditional boundaries of disease-centred psychiatry. Castillo further indicates that recent advances have made it clear that behaviour, both normal and abnormal, is a product of a continuous interaction among biology, individual
thought processes, and the cultural environment. Therefore, different cultures have different understandings and explanations of behaviour that may be defined as schizophrenia in a western medical model.

According to traditional African beliefs, health signifies peace with the spirits of ancestors and supernatural beings. When sick, Africans often go to a western doctor for the treatment of the illness, but also go to a traditional doctor to divine the cause of the disease. Africans base actions, beliefs, traditions, and ways of thinking on the laws of causality. It is believed that every misfortune or disease is the doing of evil people or witches (Asmal, Mali, Kritzinger, Chiliza, Emsley, & Swart, 2011; Hoyle, 2010).

Additionally, traditional Africans believe that mental as well as physical illness can be caused by disharmony between a person and the ancestors (Van Dyk, 2001). Bodibe (1992) and Mbiti (1969) argue that those illnesses that occur due to ancestral dissatisfaction are usually not serious or life-threatening. As soon as the relationship with the ancestors has been restored through offerings and rituals, ill health is eliminated.

Regarding the treatment of African patients with schizophrenia, Bodibe, (1992) argues that patients are likely to believe that the treatment is only symptomatic, that is, only to control behavioural manifestations of the illness. Studies done on Basotho-speaking Blacks found that traditional medicine is usually the first choice of treatment followed by the western approach or a simultaneous combination of the two (Mosotho, Louw & Calitz, 2011).

At Soshanguve Community Health Centre, where I work, approximately 60% of the patients who get medical treatment from the mental health clinic (according to an estimate based on the clinic’s monthly mental health statistics) are diagnosed with schizophrenia. Some of these patients have been referred for psychotherapy as part of their treatment. In my
experience, the culture of these patients seems to play a very significant role in how they experience their diagnosis and the meanings they attach to it. Some of these patients feel that if they perform specific rituals they may be healed of their mental illness. These patients also argue taking medication only helps to alleviate the worst symptoms until they have the resources to perform the rituals that will appease the ancestors. It has thus become clear that the meanings some patients attach to schizophrenia differ substantially from those found in western literature. Ancestors form a very significant and fundamental part of the daily lives of traditional Africans.

Aims and objectives

This research aimed to explore the experiences and meanings attached to schizophrenia by Black African patients who receive treatment at the Soshanguve Community Health Centre, and the ways in which they understand their illness from their cultural point of view. The research also aimed to explore how the family members of these patients understand the illness from their cultural point of view, and what challenges they have to face. Three patients and three significant family members of each patient formed the basis of this study.

The objective of this study was to understand how patients who have been diagnosed with schizophrenia and their family members experience their illness from their cultural point of view. What emerged from this understanding may be used to guide future research and inform interventions involving people diagnosed with schizophrenia at the community clinics and hopefully other tertiary institutions that offer mental health services. This study also sought to add to the body of knowledge regarding schizophrenia and how Black African patients understand and conceptualise their illness.
Choosing the research method

In order to gather in-depth information and descriptions regarding the understanding of, and meanings attached to, schizophrenia by patients diagnosed with the condition, a method that allowed probing and flexibility was chosen. Phenomenology (Landridge, 2008, p. 4) is understood as “a discipline that focuses on people’s perceptions of the world in which they live and what it means to them”. Linseth and Norberg (2004) describe phenomenology as an inductive qualitative research tradition rooted in the 20th century philosophical traditions of Edmund Husserl (descriptive) and Martin Heidegger (interpretive). Finally, (Finlay, 2008) argues that phenomenological research provides a rich textured description of lived experience. The phenomenological method chosen for this study is informed by Heidegger’s philosophy which acknowledges the importance of pre-understanding when interacting with the phenomenon that is under study. The next section briefly explains my interest in the topic and how this thesis emerged.

Personal Motivation for this Thesis

I have always been fascinated by psychotic mental illness. As a Black woman who spent most of my childhood years with my paternal grandmother whose beliefs were rooted in tradition, I have tried to understand the meanings that the elders attached to psychotic mental illnesses. Psychosis seemed to be viewed by the elders as normal manifestation of cultural obligations and it was not perceived as pathological. During my Masters studies, the initial topic for the dissertation was on schizophrenia from a young Black man’s perspective; however, due to some unforeseen circumstances, another topic was chosen.
Martin Heidegger argues that we always bring our pre-understandings to any situation or phenomenon that we are studying; therefore, I bring to this thesis my professional knowledge of schizophrenia from a medical model point of view; I also bring my being as a Black woman, my cultural rootedness and the stories from my grandmother and the other elders.

**Mapping out this thesis**

The following is an outline of the chapters in this study and provides an overview of the thesis:

**Chapter Two**

This chapter examined the history of mental illness from the pre-historic era until the Enlightenment. An exploration of mental illness in the Far East, Arab countries and Africa is presented. Evil spirits and ancestral involvement are regarded as the main cause of mental illness in these countries. Finally, the history of mental illness in South Africa revealed how the apartheid regime determined the treatment and explanation of mental illness.

**Chapter Three**

This chapter discussed the relationship between religion and mental illness. Christians use the Bible for guidance, and scriptures serve as a reference for dealing with life challenges. This chapter explained the Biblical notions of mental illness and different ways of treating mental illness. Mental illness is examined in different eras, that is, from the Middle Ages through to the Renaissance, and in different religious belief systems such as Islam.
Chapter Four

This chapter examined the many biomedical theories that claim to explain what causes schizophrenia. The historical examination of the concept showed that there is no change regarding the explanation of schizophrenia; the historical overview shows that the more things change, the more they stay the same.

Chapter Five

This chapter explored the psychological theories of schizophrenia and an attempt is made to explain schizophrenia from the psychological point of view. This chapter highlighted the importance of relationships and shows how a distortion in the way we relate can potentially lead to the emergence of schizophrenia. The family is described as a system and the various family dynamics that may cause schizophrenia were examined. An examination of the General Systems Theory was also presented in this chapter.

Chapter Six

This chapter presented mental illness and culture and discusses how different cultures conceptualise mental health and mental illness. A comprehensive examination of culture-bound syndromes across the world was presented. The thin line between what is deemed normal and what is seen as abnormal is made apparent. The role of traditional healers and the African traditional churches in mental health cannot be over-emphasised.

Chapter Seven

Schizophrenia is a family illness; it affects everyone who is connected to those diagnosed with the illness. This chapter examined how families have to adjust their
functioning as roles are changed due to the illness. Parents are taken care of; siblings are forced to take care of their ill brother or sister and wives have to take on the role of husbands.

Chapter Eight

This chapter introduced the concept of phenomenology and examines the phenomenological movement from the preparatory phase of Franz Von Brentano and his colleagues to the French phase of Sartre and his colleagues. Of importance here is the hermeneutic circle which informs us about the position of the interpreter in relation to the phenomenon during interpretation and how understanding is facilitated by that awareness. Hans-Georg Gadamer also played a very significant role in hermeneutics, and this chapter highlights his insights pertaining to language, historicity and understanding, and how one cannot ignore their importance when interpreting the text. Martin Heidegger emphasises the significance of our pre-understandings when interacting with the text in contrast to Husserl’s bracketing notion.

Chapter Nine

This chapter presented the methods used for this thesis. The basic assumption of hermeneutic phenomenology studies is that there are no prescribed steps to be employed when undertaking research. A description of my pre-suppositions provided context in terms of what it is that I brought to this study; this knowledge was discussed together with the participants’ stories in the next chapter.
Chapter Ten

This chapter presented the story tellers and their families. The family dynamics discussion of each family was an attempt to develop a possible hypothesis in order to understand schizophrenia symptomology from a family systems perspective. The discussion of family dynamics in this chapter is a non-judgmental attempt at explaining the relationships that are apparent in these families.

Chapter Eleven

This chapter analysed the stories, and excerpts from the interviews are used to clarify the themes discussed. The words and the language used by the participants were used to reveal the phenomenon that is being discussed.

Chapter Twelve

This chapter integrated the findings of this thesis with the available literature. The everyday taken-for-granted struggles of families and patients who are diagnosed with schizophrenia were revealed.

Chapter Thirteen

This is the final chapter that brought everything together. It started with a narrative that illuminated the beginnings of this journey and ended with the final thought. The middle part of this chapter puts forward the fusion of my horizon with the storytellers’ horizons.
Implications for practice, suggestions for further studies and the limitations of this thesis are presented as well.
My good fortune is not that I have recovered from mental illness.
I have not, nor will I ever. My good fortune lies in having found my life.

Elyn R. Saks: The Centre that cannot hold: My Journey through madness
Chapter 2
Mental illness

We do not have to visit a madhouse to find disordered mind; Our planet is the mental institution of the Universe.
Goethe

This chapter explores the literature available on the topic of mental illness, starting with definitions and a historical overview. The historical overview will examine mental illness from the prehistoric era to the ancient world, medieval and early modern Europe and the Enlightenment period. There will also be a discussion of how mental illness is conceptualised in different countries, starting with the Far East, and Africa. The medical model explains mental illness from a Eurocentric point of view; therefore, the medical model explanation of mental illness covers views prevailing in European countries. It should be noted that the terms ‘madness’ and ‘insanity’, which are deemed derogatory, will be used in this thesis only to emphasise the terminology current at a particular time.

Defining Mental Illness

Parle (2007, p. 9) defines mental health as a “rubric, a label which covers different perspectives and concerns such as the absence of incapacitating symptoms, integration of psychological functioning, effective conduct of personal and social life, feelings of ethical and spiritual wellbeing and so on”. Parle adds that all societies have a concept of desirable states of being that are characterised by something wider than the absence of mental illness, and that culture determines both the perception and level of concern in the case of each of these qualities.
The World Health Organization (2001) perceives mental health as an integral and essential part of health. It defines health as a state of complete physical, mental and social well-being and not merely the absence of disease and infirmity. Mental health, therefore, is defined by the WHO as a state of well-being in which an individual realises his or her own abilities, can cope with normal stresses of life, can work productively and make a contribution to his or her own community. According to the WHO (2001), persistent socio-economic pressures are recognised risks to the mental health of individuals and communities. Poor mental health is also associated with rapid social change, stressful work conditions, gender discrimination, social exclusion, unhealthy lifestyles, risks of violence and physical illness-health and human rights violations.

Hargrove (1982) on the other hand defines mental health as the ability to be sufficiently in touch with reality; both the physical reality of one’s surroundings and the social and conceptual reality of one’s culture, and to function effectively as a member of society. Therefore, mental illness is considered to be a condition where one is so out of touch with those surroundings that one is in danger of harming either oneself or others, or of destroying the social fabric upon which both the self and others depend (Hargrove, 1982).

Parle (2007) argues that mental illness should be regarded as a continuum, ranging from widely-recognised and clearly-named forms of deviant or disruptive behaviours (‘madness’) at one extreme, through to states of mind that are distressing and even disturbing, but that do not require drastic measures, individual or collective, for their alleviation. Parle further contends that the significant value of this broad concept of mental health permits us to reject the strict dichotomies between mental illness (insanity, deviance, pathology, madness) and a clearly-defined and recognisable state of health. Finally, Cilliers & Retief (2009) point out that the precise definition and classification of mental illness remains an extremely
challenging problem, inextricably interwoven over centuries with cultural, religious and educational views.

**Historical Overview of Mental Illness**

**Prehistoric Era**

The notion of mental illness has always been a puzzling one, even during the Stone Age period. Swanepoel (2009) states that mental illness in prehistoric times was thought to originate from magical beings which affected the person’s mind; it was universally believed to be caused by supernatural phenomena, and it represented a breakdown of the magico-religious system. According to Campbell (1976), people who developed mental illness were either thought to be possessed by demons or seen to be responsible for their illness by violating or failing to observe ritual obligations. Treatment included consultations with the shamans, and exorcism was conducted in an attempt to persuade the evil spirit causing the illness to leave the individual.

Trepanation, which is a procedure in which the skull is cut open, was believed to enable the exit of the evil spirit from the afflicted individual. Evidence of trepanation has been found in the remains of prehistoric humans from Neolithic times, and the bone removed during surgery was worn as a charm to ward off evil spirits (Free Online Dictionary, 2012). From ancient times until the 18th century, mental illness was treated and understood as both a physical and a metaphysical disorder by observers, victims and healers of madness (Eghigian, 2010).
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The Ancient World

Hippocrates (460-377 B.C.) was a physician from the Greek Island of Cos, and his ideas and practices have shaped medicine in the western world up to this very day (Lefkowitz & Fant, 2005). Hippocrates was a member of the cult of Aesculapius and the first person in history to give clinical psychiatry a biological basis. His thinking sought to establish a relation between the symptom, the morbid process and the physiopathology of the humours by going back to the model of the physiologists (Roccatagliata, 1991). He was one of the first writers to challenge the belief in supernatural causes of mental illness (Swanepoel, 2009).

Lefkowitz and Fant (2005) point out that Hippocrates’ followers believed that disease was the result of an imbalance within the body of fundamental body fluids, which were called the humours (blood, phlegm and bile). These physicians rejected spiritual explanations and treatments and looked instead for environmental factors, diet and lifestyle. Hippocrates believed that the body must be treated as a whole and not just as a series of parts (Swanepoel, 2009). According to Hippocrates:

Men ought to know that from the brain and from the brain only arise our pleasure, joy, laughter, and jests, as well as our sorrows, pains, griefs and tears… it is the same thing (the brain) which makes us mad or delirious, inspires us with dread and fear, whether by night or by day, brings sleeplessness, inopportune mistakes, aimless anxieties, absentmindedness, acts that are contrary to habit… madness from moistness… the corruption of the brain is caused not only by phlegm but by bile. You may distinguish them thus. Those who are mad through phlegm are quiet, and neither shout nor make a disturbance; those maddened through bile are noisy, evil doers, and
restless, always doing something inopportune. These are the causes of mental illness. But if terrors and fears attack, they are due to a change in the brain (Swanepoel, 2009, p. 68)

According to (Shapiro, 1981) Hippocrates believed that hysteria, depression and post-partum psychosis originate from sexual urges and he recommended marriage and frequent intercourse as treatment.

Lefkowitz and Fant (2005) discuss the causes and treatment of one of the most debated ailments in the history of madness, namely hysteria. The womb was considered to be responsible for all women’s diseases; when it was displaced, either forward or backward, it caused diseases. There were different procedures that were carried out on a displaced womb, which ranged from application of ointments to insertion of pessaries to induce menstruation. Hysterical suffocation is described as a condition where a woman loses her voice and her head and tongue are overcome by drowsiness, and this happens when the womb remains in the upper abdomen.

During the 3rd century, Plato (428-347 B.C.) declared that there were two kinds of mania, one that involved a mental strain that arose from a bodily cause of origin, and the other due to divine or inspired manifestations, with Apollo as the source of inspiration. The latter kind is now called divination, but in earlier times it was called madness. The Stoics also pointed to two kinds of madness; one kind consisted of lack of wisdom, therefore, a foolish man was considered mad; the other kind involved a loss of reason and a related bodily affliction (Drabkin, 1955). According to Soranus:
madness was called mania by the Greeks because it produced a great mental anguish; or because of excessive relaxing of the soul or mind, the Greek word for relaxed or loose being *manos*; or because it makes the patient desirous of being alone and in solitude, the Greek word “to be bereft” and to seek solitude being *monusthae*; or because the disease holds the body tenaciously and is not easily shaken off, the Greek word for persistence being *monia*; or because it makes the patient hard and enduring (Greek, *hypomeneticos*) (Eghigian 2010, p. 40).

Mania occurs more frequently in younger and middle-aged men, rarely in old men and most infrequently in women and children. Soranus (Eghigian, 2010) further states that the cause of the illness is sometimes hidden, but at times there are observable causes like: exposure to excessive heat, exposure to severe cold, indigestion, frequent and uncontrolled drunkenness, continuous sleeplessness, anger, grief, anxiety, superstitious fear, a shock or blow, taking of drugs, business or other ambitious pursuits, the removal of chronic haemorrhoids or varices and, finally, the suppression of menses in women.

Eghigian (2010) describes manifestations and treatment of madness. The signs and symptoms are unhappiness, mental anxiety, tossing in sleep, immoderate appetite, frequent blinking of the eyes, palpitations, sleep marked by great fear and turmoil, abdominal distention, frequent passing of gas through the anus, and rapid pulse. Other signs and symptoms are: impairment of reason, an overpowering fear of things which are harmless. The nerves in the head are said to be responsible for the symptoms. Treatment for mania or madness is similar to that for epilepsy; the patient is made to lie in a quiet, warm and moderately-lit room. The bed should face away from the entrance of the room and should be firmly fastened down. The patient is gently held down if the body is shaking. The patient is
rubbed gently with scoured wool on the chest, head and neck. Warm olive oil compresses, fenugreek water and an infusion of marshmallow or flax seed are given to the patient. Treatment is very intense and includes bloodletting, shaving of the head, exercises, and special diet. All these archaic treatment modalities were considered efficient in the treatment of mental illnesses of the time.

**Medieval and Early Modern Europe**

This is the period between 1000 A.D and 1600 A.D and includes part of the Renaissance. This era saw the beginning of Christian care for the mentally infirm and a change in society’s attitude towards the mentally ill (Howells, 1991). Shapiro (1981) notes the revival of humanism during that era which rekindled interest in the observation and treatment of the mentally ill. There was also a growing belief that intellect was subservient to emotions and a distinction had to be made between the psychology of human behaviour and morality. Shapiro adds that psychological issues were controlled by philosophers and the major philosophical issue of the time was the mind-body problem.

It was not until the Renaissance that physicians returned to the task of describing and classifying mental illness (Torrey, 1980). Bartholomaeus divided mental illness into “melancholy (apparently including depression, anxiety, hypochondriasis and some delusional states), mania, or raving madness, forgetfulness or staring spells, delirium resulting from brain diseases and delirium resulting from systemic disease” (Torrey, 1980, p. 24). In 1570, Ludwig Lavater gave a good description of delusions and hallucinations. By the turn of the century, Shakespeare was also incorporating descriptions of delusions and hallucinations into his plays, and madness is an important feature in his work: for example, Macbeth and Hamlet experience visual hallucinations (Torrey, 1980).
Avicenna, who was a Persian poet, was one of the most esteemed thinkers of the medieval period. His renowned text, The Canon, was an attempt at reconciling Aristotelian philosophy with Galen’s medicine. The Canon influenced the Islamic as well as the western European world and mental illnesses were included in a chapter on head diseases (Howells, 1991). Love sickness, which was a delusional illness and similar to melancholia, was one of the topics discussed in The Canon (Dols & Immisch, 1992). Dols and Immisch (1992) describe the symptoms as: hollowness of the eyes; lack of moisture in the eyes except when weeping; continuous movements of the eyelids; and inappropriate laughing. There is deep sighing, which is accompanied by social alienation and withdrawal. The behaviour of the affected individual usually changed when there was mention of the beloved or when the beloved was encountered. Treatment usually entailed uniting the patient with the beloved if the religion and the law (shārī‘a) permitted.

John Brydall (cited in Eghigian, 2010) made a distinction between an idiot or natural fool and a lunatic. An idiot is a term of law and is used to describe one who is wholly deprived of his reason and understanding from birth. A lunatic on the other hand is one was of good and sound memory but who, by the visitation of God, through some sickness, grief or other accident, has utterly lost his memory and understanding, thereby falling into a high or low degree of fury or madness. Natural causes, rather than demonological ideas, were emphasised as the source of mental illness by writers of the time. Bartholomaeus Angelicus expressed this view (Howells, 1991, p 31):

Madness cometh sometime of passion of the soul, as of business and of great thoughts, of sorrow and of too great study, and of dread; sometime of the biting of the wood-bound (mad dog), or some other venomous beast;
sometime of melancholy meats, and sometime of strong wine. And as the causes be diverse, the tokens and signs be diverse.

During the medieval period, there were three main views of mental illness. The first view was based on abnormalities of the four humours; secondly, mental dysfunctions were seen to originate from disorders of the head around the cerebral ventricles. Mania or madness was ascribed to infections of the foremost cell of the head, the anterior horns of the lateral ventricles and the frontal lobes. Thirdly, melancholy was ascribed to infection of the middle cell, the body of the lateral ventricles and the parieto-temporal regions (Howells, 1991).

According to Howells (1991) and Greenshaw and Porter (1989), it was also during this period that municipalities made provision for the mentally ill in their budgets and hospitals began to provide care for such patients. In England, for example, there were 18 hospitals in 1120 but by the 12th century, there were 166 hospitals, of which 80 were used to accommodate the mentally ill. Saint Mary of Bethlem was established in London in 1247 to house people ‘deprived of reason’ and by 1403, six people were housed in this hospital. The hospital gained more and more patients and eventually developed into the infamous Bedlam. Mentally ill patients in Europe were hospitalised rather than executed, but their treatment was far from humane or therapeutic and many people continued to consider the mentally ill to be witches. The next section examines the Enlightenment Era and how the mentally ill were perceived and treated in that period.

The Enlightenment

While the ancient, medieval and early modern healers were far from passive in their treatment of the mentally ill, there was a degree of acceptance that incurable madness was a fact of human existence and that the world would never rid itself of the affliction. This view
was challenged by the intellectual movement known as the Enlightenment (1730-1800). During this era, the end of deference to traditional authorities, confidence in the power of reason and trust in scientific and social progress inspired a generation of researchers, physicians and policymakers to reconsider what they dismissed as their ancestors’ ignorant fatalism. This optimism was not shared by everyone, but it gave birth to scientific, medical and institutional experimentation (Eghigian, 2010).

This rebirth of scientific questioning in Europe led to the development of more humanitarian approaches to the understanding and treatment of abnormal behaviour. Francis Willis, one of the earliest and most famous of the ‘mad doctors’, established a private mental institution for the elite in Lincolnshire. Willis encouraged Tuke (1732-1822) and Pinel (1745-1826) to articulate what came to be known as the ‘moral treatment’ of madness (Swanepoel, 2009; Eghigian, 2010). However, Colp (cited in Swanepoel, 2009) mentions an American doctor, Rush, who argued that mental illness was somatic in origin. Rush rejected the moral treatment of mental illness and used inhumane treatment modalities which denied patients of their rights.

A period of accelerating innovation ensued during the 1800s as new categories of mental disease were identified, new causes of insanity were proposed, and a range of new treatment regimens was explored (Parle, 2007). Parle stresses the central importance of the shift, in both discourse and practice, from the custody of dangerous mentally ill people in asylums to the care, control and treatment of the mentally ill. The madhouses of the middle ages gave way to the reformed institutions of the 19th century, and the emphasis was on humane and moral treatment. The next section explains mental illness in three different geographical areas.
Explaining Mental illness

Patel (1995) maintains that there are different explanatory models of mental illness across the world and at times there are more similarities than there are differences in terms of understanding mental illness. Most cultures distinguish between the mind and the body, and share some concepts of mental illness with Euro-American concepts. Whilst psychotic illness is often recognized as madness, neurotic presentations are more varied, often somatically defined, and may not be considered to be mental disorders at all (Patel, 1995).

The Far East

The study of Chinese medical literature reveals an early awareness of the body-mind relationship and a profound understanding of what is currently known as psychosomatic medicine (Swanepoel, 2009). Swanepoel further states that any disease, not particularly mental illness, was seen to be caused by an imbalance of the two primary forces in man: the yin and the yang. The two forces signify negative and positive, dark and light, the moon and the sun, the noxious and the beneficial, both female and male elements which are present in man and woman alike. It was believed that disease occurred when the proportions of the two elements changed from the normal. It was further believed that this imbalance was caused by the patient himself or herself, who had committed a transgression by deviating from the prescribed ways of nature and society. It was this concept that provided the guiding principle of all human conduct in China.

Haque (2008) describes the Chinese belief system, which is a mixture of Buddhist, Christian, and Tao philosophies as well as ancestor worship. Chinese beliefs about mental health are primarily shaped by Chinese philosophies of the mind. Daoist philosophers were
the first to compare the human heart to the ‘emperor of the body’, which rules over the sense organs. The first textbook on Chinese medicine, ‘Yellow Emperor’s Internal Classic,’ regarded the heart not only as the essential part of the body’s cardiovascular system, but as a source of emotional and cognitive activities. The Chinese holistic theory of body and mind proposes that mental activities are a result of somatic activities and that mental health depends largely on physical health.

According to Haque (2008), early Chinese literature attributes good health to the state of emotions in a person. The circulation of the $Ch\ ii$ (air or breath) regulates emotion, which is seen as a significant aspect of the body’s basic functions. The $Ch\ ii$ is partially inborn and partially a product of one’s food and drink. $Ch\ imaintains$ the physical body and the mental and spiritual processes in the individual. Abnormal emotions affect the functions of the $Ch\ ii$: anger makes the $Ch\ ii$ rise; joy relaxes it, sorrow dissipates it, fear makes it go down; cold contracts it; heat makes it leak out; fright makes its motions chaotic; exhaustion consumes it; worry thickens it. Therefore, excessive, unbalanced, or undisciplined emotions are primarily the reason for the development of illness. This Chinese belief system includes a belief in a set of mythical gods which have powerful spirits that can be influenced by humans through certain rituals. There are also certain individuals, known as the $shen$, who have the ability to become mediums through their trances. These mediums are able to deal with the devils and deities that cause illness, thus bringing about a change in the suffering person (Haque, 2008).

**Africa**

Ancient Egyptians thought that diseases were due either to evil spirits or to the wrath of the gods. Their philosophy of life and death centred upon the idea that these were part of a continuous cycle: the belief in life after death demanded elaborate funeral ceremonies and
complex rituals in preparation for it (Swanepoel, 2009). Okasha (2001) suggests that this belief emphasised the psychology of the dead and the nature of the personality thereafter. The individual was considered to be composed of three integral parts: the ‘khat’, which represented the body, the ‘ka’ that represented the soul, and the ‘ba’, which symbolised a flying bird carrying the key of eternity. The ‘ka’ was believed to leave the body after death and reside in heaven, periodically visiting the place of the mummified body.

According to Patel (1995) the concept of disease causation and classification is intimately related to traditional religious beliefs and is shared by many African people. Patel further discusses the three fundamental ideas that underpin these attitudes and beliefs concerning causality. Firstly, there is a cause for all things that exist; and the cause is more powerful than the effect and it (the cause) possesses more rights or privileges. Secondly, occurrences which seriously affect human beings, such as birth, puberty, drought, and so on are also intentionally caused; and thirdly, the cause of any occurrence can be ascertained through divination, memory, reason and judgement based on previous experiences. Closely related to these beliefs is the idea of continuity between the living and the dead. Therefore, after death, the spirit lives on and plays an important role in maintaining the wellbeing of its living descendants. There are different spirits, some of which are malevolent and others benevolent. The family and community spirits are associated with the maintenance of good health. However, if social taboos are broken, they may cause illness and misfortune. The alien and evil spirits, on the other hand, cause illness in a random and malicious manner regardless of the daily actions of the victim.

Patel (1995) highlights the fact that traditional African concepts of health view illness in a holistic way, unlike the Cartesian mind-body dichotomy that is common in Eurocentric societies. Patel further examines how some African countries understand and explain mental
illness: In Zimbabwe the importance of traditional categories of illness was recognised before terms such as ‘explanatory models’ had become common. The conception of disease among the Shona is similar to that of most South African tribes. These tribes describe the symptoms of psychosis in ways that are similar to the European concepts of acute psychotic illness.

History of Mental Illness in South Africa

Swanepoel (2009) maintains that the history of psychiatry in South Africa stretches back to the settlement of the first Europeans in the Cape in 1652. Jan van Riebeeck established a settlement in the Cape and was tasked with building a “defensive fort” (which included a hospital); the aim of this hospital was rehabilitative.

During the 19th and early 20th centuries psychiatry was populated with an overabundance of theories that claimed that observable physical characteristics were indicative of internal abilities such as intelligence, the ability to express and experience certain emotions (such as guilt or depression), and a capacity to appreciate the benefits of civilisation (Parle, 2007). Race was conceived of in terms of hierarchies, with body type, including facial characteristics, cranial and pelvic capacity, and the angle and slope of the nose and forehead apparently indicating position and potential on the human spectrum. Racial groups that appeared different to Whites, like Jews, Indians and Africans were therefore regarded as inferior races, whose apparent cultural inferiority was linked to their physical and mental inheritance (Fernando, 1991). Dunston (1923) claimed that, due to their intellectual capacity, which was lower than that of an average White person, Blacks lacked the reasoning powers to become paranoics (sic) as they lacked brain cells. Carothers (1953) compared the African primitive mind to that of a child or an insane European. An interesting point noted by Lelyveld (1985) is that there was a time in South African history, the mid 1800s and the early
1900s, when the Afrikaners’ intellect was viewed by the English in the same light as that of the Black African.

Minde (1974) indicates that even though there are references in the old Cape records that prove that mentally ill people were incarcerated on Robben Island, no attempt was made to build a lunatic asylum on the island until much later, during the British occupation. Media reports of those detained in Robben Island paint a picture of savages who were murderous and uncontrollable.

Between 1800 and 1900, syphilis and alcoholism were the two medico-social epidemics that resulted in mental illness affecting populations of Europe and North America (Jochelson, 2001). In South Africa, a study of syphilis up to the mid-twentieth century shows that venereal syphilis was rare among the Africans in Natal and the Eastern Cape until the late 1800s and was largely associated with colonists. The South African War of 1899 to 1902 accelerated the spread of syphilis because the military garrisons and the concentration camps attracted prostitutes. Syphilis was initially a White problem, but the disease increasingly became associated with poor Whites, and later almost exclusively with Africans (Jochelson, 2001).

According to Burrows (1958), mental illness in the Cape settlements was seen as being caused by a range of factors, from poor nutrition to alcoholism, infections, exhaustion and venereal diseases, and there was no efficient record-keeping to record incidences of mental illness. In Natal during the 1800s, alcoholism was the biggest contributor to mental illness; temporarily deranged drunks (who were mostly White males) were a public nuisance and were often detained in the Colony’s prisons and many of those who experienced delirium tremens were admitted to the asylum (Parle, 2007). The problem with alcoholism got so out
of control that it became a matter of public debate, and proposals were put forward for a bill relating to the care, control and curative treatment of the European drunkards. There was, however, a new pattern of alcohol consumption that emerged amongst African males during that time (Mahoney cited in Parle, 2007). Parle, (2007) argues that the increase in alcohol consumption was seen as both a cause and a symptom of the unravelling social fabric of rural African life in Natal, as women and younger men rebelled against patriarchal authority. It seems that alcohol and sexually-transmitted illnesses were the major contributors to mental illness during the 1800s. Ure (2009) notes that there was a blurring of the lines between mental hospitals and prisons; prisons were used as hospitals and hospitals were used to admit the destitute and the inebriate.

Gillis (2012) maintains that advances have been made since the mid-20th century, in spite of the challenges that have plagued psychiatry in South Africa, such as a large population of chronic psychiatric patients. Some of these advances in modern psychiatry included outpatient facilities for psychiatric patients and the development of a multi-disciplinary team approach to psychiatric illnesses involving psychiatrists, psychiatric nurses, psychologists, occupational therapists and social workers.

Gillis, Robertson, Zabow and Stein (2012) acknowledge changes in psychiatry in South Africa as a result of the emergence of the HIV/AIDS pandemic. The HIV/AIDS pandemic highlighted the need for specialised services in neuro-HIV/AIDS. This led to the development of neuro-psychiatry and geriatric psychiatry in 2005.

The socio-economic and political structure in South Africa has hampered efforts to reduce the number of psychiatric hospital beds; this is due to a lack of adequate community and social services (Gillis, 2012). Gillis argues further that a significant number of psychiatry
patients are treated at private psychiatric clinics where highly specialised care is offered compared to the care that poorer communities get.

There have been notable changes in mental health care in this country since the colonial regime. However, it seems that the more things change the more they stay the same. During the Apartheid regime, The Reservation of Separate Amenities Act of 1953 enforced segregation of Blacks from Whites in terms of resources, and this disadvantaged the Black population (Ure, 2009). Currently, the same segregation still occurs but is based on economic resources instead of skin colour. However, the proposed National Health Insurance promises equal mental health care to all South African citizens (Gillis, 2012).

Summary

This chapter examined the history of mental illness from the prehistoric era until the Enlightenment. During the prehistoric era, it was believed that mental illness was caused by magical beings that affected people’s minds; Hippocrates during the ancient period claimed that there is a biological basis for mental illness and the Greeks used the term mania to describe ‘madness’. Christian and humane care of the mentally ill began during the medieval period. The Enlightenment period marked the beginning of moral treatment of mental illness and the acceleration of innovations in terms of the treatment of mental illness. An exploration of mental illness from the Far East, Ancient Egypt and Africa was presented. The involvement of evil spirits and ancestors was regarded as the main cause of mental illness in these countries. Lastly, the history of mental illness in South Africa reveals how the apartheid regime determined the treatment and explanation of mental illness. Current studies reveal challenges and achievements in the field of psychiatry. The next chapter examines religion and mental illness.
The White man is very clever. He came quietly and peaceably with his religion. We were amused at his foolishness and allowed him to stay. Now he has won our brothers, and our clan can no longer act like one. He has put a knife on the things that held us together and we have fallen apart.

Chinua Achebe, Things Fall Apart (1958)
Chapter 3
Religion and Mental Illness

Introduction

Religion and spiritual issues play an important role in shaping patients’ perceptions of their health and how they manage their illnesses. This chapter presents a historical overview of religion and mental illness as well as religion and psychiatry, starting with an explanation of different religions, namely Christianity, Islam and Buddhism. The following will be discussed: the benefits of religion in psychiatry, delusions with religious content and, lastly, how a distinction can be made between religion and mental illness.

Defining religion

Mohr and Pfeifer (2009, p. 84) give a broad definition of religion “which includes both spirituality (which is concerned with the transcendent, addressing the ultimate questions about life’s meaning) and religiousness (which refers to specific behavioural, social, doctrinal and denominational characteristics)”. Religion is regarded as “the larger social and institutional context in which the search for the sacred takes place” (Pargament, 2007, p. 122). Wig (1999, p.96) argues that defining spirituality is complex; the dictionary definition which states that it is “a system which affirms the existence of immaterialreality imperceptible to the senses” or any philosophy accepting the notion of an infinite personal God or immortality of the soul does not seem to cover all the various ways in which the term is understood. What, then, the essence of spirituality? In some ways it is nothing, and in some
ways it is everything. As Tao Te Ching, the great Chinese book of wisdom states (trans. by Stephen Mitchell):

We join spokes together in a wheel,
but it is the centre hole
that makes the wagon move.
We shape clay into a pot,
but it is the emptiness inside
that holds whatever we want.
We hammer wood for a house,
but it is the inner space
that makes it liveable.
We work with being,
but non-being is what we use. (Wig, 1999, p. 96).

During the first half of the 20th century, religion was widely accepted as being inclusive of both institutional and individual experience; however, the cultural uprisings of the 1960s and 1970s resulted in increased disillusionment with traditional institutionalised religion. This led to a drifting away from traditional institutionalised religion and a trend towards the individualisation of religion (Russinova & Cash, 2007).

**Historical Overview of Religion and Mental Illness**

The Bible is the most globally influential of ancient religious texts and has influenced the West since the time of Constantine; it is therefore important to understand how the Bible presents madness (Thielman, 2009). Thielman (2009) argues that the history of psychiatry has often been written as though there was a flawless transition from superstition to reason, from religion to science, and that only in the modern era has it been understood that madness
is not caused by spirits, demons or curses. In the New Testament, madness is sometimes attributed to demons. In the Gospel of John, Jesus’s opponents at one point say: “He is demon possessed and raving mad; why listen to him?” (Thielman 2009, p.7). Thielman further states that the Bible contains not only information on an ancient way of viewing madness in spiritual terms, but also large portions of wisdom literature that is similar to modern self-help literature. The books of Proverbs, Ecclesiastes, Wisdom and Sirach all contain advice on how to live life and how to understand life’s difficulties.

Edelstein and Edelstein (cited in Thielman, 2009) explain that one of the principal methods of healing in the temple was to make a ritual offering of a small replica of the diseased organ and wait for healing. Healing often came through dreams in which Asclepius would appear. The Asclepian physicians were practitioners of rational medicine who, when they could not heal through this means, directed the sick to the Asclepian temple. Temkin (1991) indicates that the Hippocratic writings and Plato played a significant role in religious circles of the West.

Thielman (2009) reports that early church writers generally respected the work of physicians and had a view of madness that incorporated a spiritual perspective, while acknowledging the physical influences that cause mental distress. Whittaker (1982) argues that not all of the early writers held this balanced view of mental illness. Tatian (c. 160), who was a skilled speaker and theologian, asserted that sickness was caused by demons and that the cure for madness is from God, not the amulets that madmen were supposed to wear. Tatian was not in favour of the wearing of amulets and argued as cited in Thielman (2009, p. 9) that:

A disease is not killed by antipathy, nor is a madman cured by wearing amulets. These [cures from amulets result from] visitations of demons…How can it be right to
ascribe help given to madmen to matter and not to God? [The] skill [of those who use such means to cure] is to turn men away from God’s service, and contrive that they should rely on herbs and roots.

During the Middle Ages, the Leechbook, which was compiled in England in the 9th century and owned by a physician called Bald, contained remedies for all sorts of ailments. Many of the remedies are plant-based, but the book contains incantations and rituals to be used in the treatment of diseases (Thielman, 2009). The book distinguishes demon possession from lunacy; for demon possession, the physician is to treat the possessed individual with a herbal concoction: “for a demoniac, when the devil possesses the man or controls him from within the disease, a spew drink or emetic, lupin, bishopwort, henbane, cropleek, a pound of these together; add ale for a liquid and let it stand for a night, add fifty libcorns, or cathartic grains, and holy water” (p. 9). The mixture is then put into every drink that the possessed man will drink (Thielman, 2009).

During the Renaissance there was a move away from the supernatural explanation of mental illness. Later, the Puritan writers, because of their concern with spiritual experience, conversion and the inner spiritual life, were often attuned to the existence of states of mental distress and despair. Many offered pastoral advice that reflects concern for the psychological well-being of the individual and provides a variety of spiritual explanation and remedies (Thielman, 2009). The next section focuses on different religious practices and how they impact on mental illness.

Different Religions and Mental Illness

This section will discuss some of the world’s different religious practices and how they explain and treat mental illness.
Christianity and Mental Illness

Religion contributes significantly to the understanding and care of the mentally ill. In the early Christian churches, mental illnesses were thought to be caused by demonic possession, and sacramental healing and exorcism were practised (Huguelet & Mohr, 2009). The Christian notion of compassion for the poor and suffering led to the creation of hospitals for the mentally ill; however, during the Inquisition, this trend changed, and Christian churches showed cruelty towards the mentally ill (Huguelet & Mohr, 2009).

At a psychological level, religion gives some patients a sense of self, as well as hope, comfort, love, compassion, self-respect and self-confidence; for others, religion gives meaning to their illness mainly through positive religious connotations, such as the view that it is God’s gift to induce spiritual growth, or the spiritual acceptance of suffering. The negative connotations may include the perception that God is punishing the sufferer, or the belief that the devil has power to induce illness or that demons are responsible for ill health if one is not wholly committed to one’s religious faith (Huguelet & Mohr, 2009).

Islam and Mental Illness

According to Endress (2002), the Islamic faith, which originated around the 7th century in the Arabian Peninsula, is the youngest of the major monotheistic religions in the Middle East. The Islamic religion argues that human beings are composed of both body and soul. The body and soul together form the psyche (nafs) which manifests in certain behavioural changes. Therefore, Islam perceives human behaviour to be the result of the
dynamic interplay between material and non-material forces and under the control of human consciousness. For a total understanding of man, a study of both these forces is necessary.

Haque (2008) maintains that while the body is in need of physical pleasure and tends to overstep its bounds, the spiritual intelligence in man intervenes to strike a balance in human personality. Haque further argues that on-going purification of thought and deeds brings a person closer to God and keeps them mentally healthy.

Ally and Laher (2008) point out that mental illness was thought to be due to evil spirits and jinns. A jinn is a supernatural spirit which is lower than the angels and can be either good or bad. Therefore, a person can be possessed by either a good or a bad spirit. Jinn possessions are characterised by bizarre behaviour and odd movements that may be considered to be either psychotic or non-psychotic disorders. Depression is also ascribed to the vengeance of jinn. Therefore one could not generalise punishment or condemn the mentally ill unconditionally. According to Swanepoel (2009), Islam also had another, more positive view in which individuals who were mentally ill were seen as being innovative, creative and original, or attempting to find alternatives to a static and stagnant mode of living.

The mystical traditions of Islam provided traditional religious healing, and Islamic hospitals were built during the 9th and the 10th centuries; prayers and incantations were encouraged as choice of treatment (Huguelet & Mohr, 2009). Management of mental disorders in the Islamic religion involves prayers repeated several times and oral administration of the ink solution obtained by washing off passages from the Koran inscribed on slates. Passages from the Koran are also made into charms or amulets which the individual wears on their person or carries about in their pocket. These are designed to drive out evil spirits, fortify the individual against further violations and surround him or her with
benevolent spirits (Sijuwola, 1995). The Koran’s teachings were the source of medical practices that spread throughout the Islamic world (Dols & Immisch, 1992). The Islamic traditional healers (moulanas, sheikhs or matawaas) are the mediums through which mental illness is dealt with; they are considered to be well equipped to drive out the evil spirit or the evil eye (Syed, 2003).

**Buddhism and Mental illness**

There is a common saying in Sri Lanka among the Buddhists that *Sabbe putujana ummakata* (all human beings are somewhat mentally ill until they are enlightened) (Piyananda, 2012). According to Piyananda, Buddha could easily be named the world’s first clinical psychologist because his teachings reflected his analysis of the mind; he taught and applied his wisdom concerning the functioning of the mind in order to promote subjective well-being and personal development. The Buddha advocated the notion of ‘seeing things clearly as they are’, which was another term for the opposite of delusion (*moha*), which is a major cause of human suffering. Being able to see things clearly as they are is a necessary requirement for achieving enlightenment. Treatment usually included the use of *Vitakka Santhana Sutta* (the removal of distracting thoughts). In today’s psychological terminology, these are called thought displacement (substitution); aversion therapy (examination of danger); sublimation; thought analysis (stilling thought-formation) and will power.

The *Dvedha Vitakka Sutta* (two kinds of thought) entailed dividing thoughts into classes. Unwholesome thoughts of sensual desire, ill-will and cruelty were one class, and their opposites were wholesome thoughts of renunciation, loving kindness and compassion. The Buddha appealed to individuals to always be careful of their thoughts, speech, actions, feelings and behaviours so that they could protect the luminosity of their minds. Individuals
were urged to take responsibility for their lives, thus they should refrain from complaining and blaming others, and stop looking to the outside for causes of things rather than to the inside of their own minds. Verse 50 of the Dhammapada (Piyananda, 2012, p.181) echoes this sentiment:

Let none find fault with others;
let none see the omissions
and commissions of others.
But let one see one’s own acts,
done and undone.

Buddha taught that the original mind was radiant, but it soon became soiled with the accumulation of defilement from outside such as greed, hate or anger. The Buddha suggested the use of bhavana to cleanse the mind of impurities and disturbances, such as lustful desires, hatred, ill-will, indolence, worries, restlessness, scepticism and doubts. It is evident from the teachings of Buddha that individuals need to take responsibility for their mental condition. The next section discusses African traditional religions and their importance in meaning-making for those diagnosed with mental illness.

**African Traditional Religion**

Religion is a fundamental influence in the life of most Africans; however, its essential principles are largely unknown to non-Africans, who misunderstand the African worldview and beliefs (Awolalu, 1976). Addo (2002) suggests that traditional African religion is centred on the existence of one Supreme High God; however, the Europeans who spread Christianity in Africa never appreciated the African’s own conception of the Great
Creator. Kaphagawani and Malherbe (1998) cite Appiah’s argument that religion in the contemporary West is different from what it is in traditional life, and that to explain it using Western categories will create misunderstandings (Kaphagawani & Malherbe, 1998).

Adeolu (2006) is convinced that over the years African traditional institutions have thrived on religion and that religion served as the structure around which all other institutions, such as cultural, economic, political and social organisations, are built. African thought holds that created beings preserve a bond with one another, an intimate ontological relationship, and that there is an interaction of being with being. This is more so among rational beings, known as Muntu, which include the living, the dead and God (Temple in Onyewuwenyi, 1998). Africans know and feel that they are in intimate and personal relationship with other forces acting above and below them in the hierarchy of forces due to the ontological relationship among beings. The present world is closely connected with the world after death, and one lives in close contact with one’s ancestors and other spirits (Nyamiti, n.d).

In African traditional religion, there is a strong belief in many gods, and this takes the form of the vhadzimu, the ‘living dead’ in English (Muneno, 1994). Muneno indicates that the living dead are the spirits of those who have passed from the physical state of existence and moved to a spiritual state. The living dead are believed by Africans to be a link with the supreme God; they play a very important role in African traditional religion and are consulted in times of trouble. According to Ashdown (2012), the African typically views man as being composed of a physical body and non-physical elements. The physical is doomed to die and waste away, while the spiritual essence of a person continues to live down through the ages; hence most Africans believe in a spiritual world comprised of divine spirit entities.
The belief in the existence of spiritual beings is widespread, as is the belief that the spiritual beings were created by God and are subject to God (Mbiti nd). The lesser beings, such as gods and divinities, occupy a lower position, but higher than that of humans; they are actively involved in the everyday religious life of traditional Africans, whereas the Supreme Being is not directly involved in everyday religious practices of the people but is mentioned in songs, prayers and in some religious ceremonies (Turaki, 2000). Van Staden (1998) points out Steve Biko’s argument that Africans did not believe that religion could be featured as a separate part of their existence on earth; it was manifest in their daily lives. Africans thanked God through their ancestors before they drank beer, married, and so on.

Addo (2002) maintains that Africans traditionally believe that, since God’s holiness blinds, He cannot be approached by mere mortals and must therefore be approached by spirits invisible to mere humans; therefore, the ancestors are often regarded as mediators between the Supreme Being and their earthly kin (Nyamiti, 2013).

Van Staden (1998, p. 29) describes Steve Biko’s view of some of the African cultural concepts as follows:

All people are agreed that Africans are a deeply religious race. In the various forms of worship that one found throughout the southern part of our continent there is at least one common basis. We all accepted without any doubt the existence of a God. We had our own community of saints. We believed that all people who died had a special place next to God. We felt that a communication with God could only be through these people…

Father Schmidt in Awolalu (1976, p. 3) states that: “the belief in, and worship of, one supreme deity is universal among all really primitive people — the high God is found among them all, not indeed everywhere in the same form or with the same vigour, but still
everywhere prominently enough to make his dominant position indubitable”. However, (Awolalu, 1976) adds that changes due to urbanisation resulted in the evolution of the African traditional religions, but this does not mean that they are extinct.

Christian churches in African countries incorporate a substantial proportion of local culture into their practices and their treatment of mental illness. Treatment involves fasting, prayers and the application of holy water. Prayers and night vigils accompanied by drumming and singing often produce cathartic effects; this may lead to the alleviation of symptoms (Sijuwola, 1995). Mbiti (2007) describes spirituality as a great value in African religiosity; it comes through prayers, invocations, rituals, offerings and sacrifices. Spirituality helps Africans to gain insight into inexplicable accidents, sudden deaths, protracted illnesses and other challenges (Molobi, 2005).

Finally, McCann & Clark (2004) argue that spirituality represents an important means of support for those diagnosed with a mental illness. Being mentally ill heightens awareness of the importance of existing spiritual beliefs in some participants’ lives; for others, it reawakens spirituality as a focus in their lives; and for some, it is transformed into delusional beliefs about their illness.

**Benefits of Religion in Mental Illness**

The Bible is an important resource to which people of faith turn in their search for mental health. Those who are struggling with emotional and spiritual burdens will open their Bibles, hoping to find some word that will ease their suffering, answer their doubts, remove their depression, bring security and assure them that they are loved and accepted by God (Simundson, 1989).
Religion can help instil a positive sense of self, decrease the impact of symptoms and provide social contact (Mohr, Borras, Rieben, Betrisey et al., 2010). In the United States of America, the moral treatment of the mentally ill arose from the European system of care which involved compassionate psychological and spiritual treatment of the mentally ill. This treatment modality originated from the assumption that insanity was caused by a disruption of both the body and mind and the spirit (Taub, cited in Reeves, 2009). Reeves adds that spiritual care formed part of the care received in those days, until around 1908 when Freud wrote vigorously against religion and when attitudes towards religion became negative. However, things are happening now to reverse this trend, the most recent being research demonstrating the value of spirituality for both medical and psychiatric patients (Koenig in Reeves, 2009). There is some evidence that religion and spirituality may be harmful for patients with psychosis; thus, spiritual and religious concerns may become part of the problem as well as part of the recovery (Arehart-Treichel, 2006; Russinova & Cash, 2007; Huguelet & Mohr, 2009).

Some people report that they experienced organised religion as a source of pain, guilt and oppression (Mohr et al., 2010). For some patients, religion was a positive source of recovery, and the faith community was welcoming and hospitable; for others it was stigmatising and rejecting. Some felt uplifted by spiritual activities and others felt burdened by them. Some felt comfort and strength and others felt disappointed and demoralised (Fallot, 1998; McCann & Clark, 2004; Maunu & Stein, 2010).

Simundson (1989) argues that it is hard to proclaim the gospel of love and acceptance by God when one is caught in a living hell where everyone and everything is an enemy; even the “good” passages about God’s love can be twisted into another expression of judgment (e.g., “I am unworthy of such love” or “I must really be bad because I can’t even believe
that”, or “If that is really true, God would not let me suffer like this if I didn’t deserve it”). Simundson adds that the language of Psalms continually mixes images of physical, mental and spiritual torment: “When I declared not my sin, my body wasted away through my groaning all day long. For day and night, thy hand was heavy upon me; my strength was dried up as by the heat of the summer” (Ps 32: 3-4). “O Lord, rebuke me not in thy anger, nor chasten me in thy wrath. Be gracious to me, O Lord, for I am languishing; O Lord, heal me, for my bones are troubled. My soul is sorely troubled. But, thou, O Lord — how long?” (Ps 6: 1-3).

Huguelet and Mohr (2009, p. 71) agree that “religiousness may exert a harmful influence through religious movements/churches that discourage psychiatric care or amplification of morbid cognitions by religious considerations”. However, a cross-sectional study of 115 patients shows that only two have been negatively affected by religious communities (Mohr, Brandt, Borras, Guilieron & Huguelot (2006). Simundson (1989) indicates that how one reads the Bible can contribute to the problem or to the solution; if one is already mentally disturbed, the Bible can contribute to the problem. There are many passages in the Old and the New Testament which speak of a judging God who will not tolerate sinful behaviour and will finally punish us in a way that is appropriate for such terrible sins (Simundson, 1989).

Studies on the role of religion/spirituality in the process of coping with mental illness have suggested that “religious coping serves five purposes: spiritual (meaning, purpose, and hope), self-development, resolve (self-efficacy), sharing (closeness, connectedness to a community), and restraint (help in keeping emotions and behaviour under control)” (Huguelet & Mohr, 2009, p. 72). The above authors give the example of a patient who has delusions of persecution and who reads the Bible when he feels he is in danger. The patient says that
reading the Bible gives him a sense of protection and helps him to control his acts of violence. The other example is that of a patient with anxiety, depression and negative symptoms. He says, “I am spiritual in my heart, my way of meditating is to sing. There is a link between the breath and the spirit. When I sing, I don’t feel as depressed and I am more enthusiastic about doing things” (p.73).

McCann and Clark (2004) found that spirituality represented an important means of support for participants. Being mentally ill heightened awareness of the importance of existing spiritual beliefs in some participants’ lives; for others, it reawakened spirituality as a focus in their lives; and for some, it led to delusional beliefs about their illness. Having spiritual beliefs helped give meaning to the illness, provided a sense of inner warmth, and relieved the burden of being mentally ill and the sense of despair and isolation.

Koenig (2009) argues that religious involvement may also encourage compliance, because religious people are taught to respect authority and be responsible. The Bible encourages the faithful to obey authority figures. Some of the scriptures in the Bible that encourage submission to authority present the following kind of exhortation:

Obey your leaders and submit to their authority. They keep watch over you as men who must give account. Obey them so that their work will be a joy, not a burden, for what would be of advantage to you (Hebrews 13:17).

Spirituality is perceived by Gockel (2009) as a meaning system, and it is assumed that the meanings we construct guide our perceptions and experiences. Huguelet and Mohr (2009) explain that even if these meanings are negative in religious terms, they are positive in
psychological terms, as they foster an acceptance of the illness or a mobilisation of religious resources to cope with the symptoms.

**Delusions and Hallucinations with Religious Content**

Delusions and hallucinations with religious content have been a subject of interest in psychiatry for the past two hundred years. These symptoms are found mainly in individuals with schizophrenia and mood disorders (Mohr & Pfeifer, 2009). Mohr and Pfeifer state that, over the past thirty years, an interesting body of literature has tried to approach the topic of religious delusions in more objective scientific terms using psychopathology, anthropology and cultural sociology on the one hand and neurobiological techniques on the other hand to explore the nature of this phenomenon.

Gearing, Alonzo, Smolak and McHugh (2010) make a distinction between religious and supernatural delusions and hallucinations. A person is considered to be having religious delusions if the content of their delusions and hallucinations includes a direct reference to a religious theme, for example, prayer, sin, or possession, and if they involve religious figures like God, Jesus, the devil or a prophet. Supernatural delusions and hallucinations include general reference to mystic forces like black magic, spirits, demons, ghosts, voodoo, sorcery and bewitchment.

Getz, Fleck and Strakowsli (2001) indicate that guilt and sin are dominant features in religious delusions and hallucinations. Regarding the incidence rate of delusions and hallucinations with religious content within various religious groups, different studies have yielded contrasting results. Getz et al. argue that Protestant patients display more religious delusions and hallucinations than Catholic and non-religious patients. On the other hand, Stompe et al. (2006) maintain that there is a higher rate of religious delusions and
hallucinations in Catholic patients than in Protestant and Muslim patients. It should be noted that these differences could be due to methodological variables. Interestingly, a study by Rudalevičiene (2008) showed that the individual’s faith is not a predictor of religious delusions in schizophrenia; however, visual hallucinations seem more prevalent in people who are very religious. The next section explores the difference between religious manifestations and psychopathology.

Separating Religion and Psychopathology

According to Koenig (2009), 25-39% of people with schizophrenia have religious delusions. Studies on delusions and hallucinations emphasise the continuity between normality and psychopathology, the multidimensional character of the symptoms and their common ground due to the key role of beliefs in giving meaning to strange experiences (Mohr & Pfeifer, 2009). Mohr and Pfeifer add that culture creates a framework of symbols that allows for meanings to be created, among them religious beliefs. Therefore, the clinician is confronted with the problem of distinguishing between religious beliefs and religious delusions. O’Connor and Vandenberg (2010) add that the challenge for clinicians is to identify and acknowledge a clinically relevant phenomenon while respecting the patient’s faith.

There are three criteria used by Sims in Mohr and Pfeifer (2009, p. 90) to distinguish between religious beliefs and religious delusions:

1. The experience reported by the patient gives the impression of a delusion.
2. Other psychiatric symptoms are present.
3. The outcome of the experience seems more like the evolution of a mental illness, rather than a life-enhancing experience.
The fundamental step in separating religious beliefs from religious delusions lies in the functionality of the belief. If the religious belief is a source of emotional distress or impaired behaviour and social functioning, then it is a delusion (Mohr & Pfeifer, 2009). General themes of religious delusions are: persecution (often by evil or demons), grandiosity (believing oneself to be God, Jesus or an angel), belittlement (to have committed some unforgivable sin) and being controlled (possession).

Julian of Norwich (circa 1342-1416) had visions of Jesus and these “shewings” (showings), as she referred to them, persuaded her to dedicate herself to living a life aimed at spiritual perfection. To do this, she had to shut herself up in an isolated cell attached to what is now known as St Julian’s Church (Eghigian, 2010). Julian’s behaviour raises questions regarding the difference between profound devotion and insanity. Eghigian further adds that, like their ancient counterparts, observers during the second millennium frequently considered unusual or unconventional expressions of religious faith to be signs of insanity. Suhail and Ghauri (2010) suggest that there has been a link between spirituality and psychotic experiences for many decades. Due to their set beliefs, people with religious delusions demonstrate poor compliance with medication when compared to those with non-religious delusions (Mohr, Borras, Rieben, Gillieron, Brand et al., 2010). Suhail and Ghauri argue further that an experienced clinician may use the link between religiosity and symptoms of psychosis to manage the condition.

Summary

This chapter discussed the relationship between religion and mental illness. Christians use the Bible for guidance, and scriptures serve as a reference for dealing with life challenges. The New Testament explains mental illness as being caused by demons; rituals
and offerings were used for healing. Sacramental healing and exorcism were also used by Christians to dispel demons. During the Middle Ages, plants were used as remedies for mental problems. The beginning of the Renaissance saw pastoral advice being used for psychological well-being. During that era, spiritual issues were seen as the cause of mental illness. According to the Islamic faith, the evil eye or the jinn is responsible for mental illness. Spiritual healers are consulted to drive away the evil spirit. The next chapter examines the concept of schizophrenia.
That Bloody Black Dog

That bloody black dog won’t leave me alone,
I wish he’d leave, I’d even give him a bone
He runs through my brain,
Causing all sorts of pain,
He does tricks to keep me unwell,
I wish that dog would rot in Hell.

My doctor says he’ll go away if I feed him pills
But he never does, he just causes me ills,
He barks all night and stops my sleep,
When strangers come he doesn’t make a peep,
He sh*ts on the floor when my friends come around,
He jumped the fence when locked in the pound.

That bloody black dog ruins all my fun,
When I want to relax he wants to run,
When I go out with my friends,
He follows me and paranoiac messages he sends,
Sometimes it feels like he blocks out my sun,
I’d shoot that black dog if I had a gun.

Psychologist says “forget him get on with your life”,
But that bloody black dog just causes more strife,
Perhaps he’ll leave as I get older,
But I suspect he’ll get bolder,
And haunt me till my dying day,
That bloody black dog just won’t “STAY”

Ralph Nelson (Minds Unleashed, 2009)
Chapter 4

Schizophrenia

*If the only tool you have is a hammer, you tend to see every problem as a nail.*

Abraham Maslow (1966)

**Introduction**

The purpose of this chapter is to trace the history of schizophrenia, from the history of the concepts to the challenges of historical research, the signs and symptoms, and the biological explanation of schizophrenia. This is a Eurocentric, biomedical model explanation of schizophrenia.

**Definition of Schizophrenia**

Schizophrenia is a complex and puzzling disease because it is characterised by a multiplicity of symptoms affecting most aspects of human cognition, emotion and behaviour. Patients may experience abnormal perceptions such as auditory hallucinations, subjectively feel that their thoughts and emotions have been taken from them, or believe that their ideas, feelings and movements are under the influence of some malevolent outside force (Andreasen, 1997, p 105). Bleuler argued that schizophrenia is a group of related disorders and not a single disease (Bernheim & Lewine, 1979).

**History of the Concept Schizophrenia**

The concept of madness as an illness had been known for as long as recorded history until the term schizophrenia was coined by Bleuler in 1911. Shapiro (1981) states that, even though there is no universality in the presentation of schizophrenia owing to differences in culture and age, people with schizophrenia have always been different from their peers in the
sense that their logic has been considered unlike the logic of others and their behaviour has been seen as odd. The modern history of schizophrenia is traced back to Kraepelin’s lecture in Heidelberg (Sedler, 1991). He combined several concepts of madness which were described separately to form a uniform concept under the general term dementia praecox (Shapiro, 1981; Sedler, 1991).

According to Sedler (1991), the first description of schizophrenia as a comprehensible clinical entity is not found until John Haslam’s essay, Observation of Madness and Melancholy, which was published in 1809. Sedler (1991) provides Haslam’s general account of an illness that was a form of insanity occurring in young adults; the subjects who presented with this illness were mostly female and were distinguished by their lively disposition. The progress of the illness was described as usually unpredictable and a source of confusion for family members who hoped that the illness was due to some character flaws and not a permanent or serious illness. Haslam further noted that these individuals initially presented with a degree of thoughtfulness and inactivity and progressed to blunted emotions with no affection towards their parents or relations. The symptoms progressed to a stage where there was increased apathy resulting in poor personal hygiene. According to Haslam, this illness was more prominent between puberty and adulthood, and the devastating effects of the illness transformed the affected person’s intellect from a promising and vigorous one to a “bloating and slavering ideot” (sic) (p. 52).

Haslam’s description of schizophrenia did not specify the course of the illness (Sedler, 1991) and it continued to be known as the “form of insanity that occurs in young people”; it had no name and was not fixed. Sedler examines Esquirol’s work, the celebrated Mental Maladies: A Treatise on Insanity in 1838. The chapter on mania and delirium describes clearly the clinical picture of schizophrenia. Esquirol described the onset of mania
as subtle, often signalled by a general and unaccountable uneasiness, various somatic symptoms, insomnia and moodiness. Although the age of onset varies, it ranges generally from twenty to twenty-five years of age. Esquirol describes in detail the typical delirium of mania (Sedler, 1991, p. 53):

Maniacs are remarkable for their false sensations, illusions, and hallucinations, and for their vicious association of ideas, which are produced, with extreme rapidity, without order or connection. They are also remarkable for their errors of judgment; the perturbation of their affections; and in fine, for their freaks of volition. This class of patients possess great nervous excitability, their delirium is general, and all faculties of the understanding are exalted and overthrown.

Shapiro (1981) mentions the different concepts that were used to describe schizophrenia: Vogel used the term paranoia in 1764; Kahlbaum described it as catatonia in 1868; and Hecker coined the term hebephrenia in 1870. According to Robbins (1993), Kraepelin argued that *dementia praecox*, or premature mental deterioration, is an organic disease of the frontal lobes; an endogenous psychosis, which is one without gross anatomic lesion or toxic factor. His use of the term dementia, which was coined by Morel in 1856, indicates his belief that the illness has a deteriorating course and poor prognosis (Robbins, 1993). Kraepelin stressed specific symptoms: hallucinations (especially auditory ones), delusions, thought broadcasting and influencing, poor judgment, disturbance of emotional expression, bizarre and stereotyped behaviour and negativism (Shapiro, 1981).

According to Shapiro (1981), Kraepelin subdivided dementia praecox into three types: catatonia, hebephrenia and paranoia, eventually adding a fourth type, simple dementia.
The term schizophrenia is derived from the Greek words *schizein* (“to split”) and *phren* (“mind”). Thus, literally translated, schizophrenia means “split mind,” a phrase that Bleuler felt captured the breaking up of normal thought processes that occurs in schizophrenia (Bernheim & Lewine, 1979, p.5). Bleuler argued that there is an underlying personality split in the patient, a loss of harmony between various groups of mental functions, and he rejected Kraepelin’s idea that schizophrenia has a progressive deterioration (Shapiro, 1981).

The following section examines the signs and symptoms of schizophrenia. It is evident from the following description that one cannot provide a concise definition of schizophrenia because of the different manifestations of the illness. Therefore, two people may have the schizophrenia diagnosis but may present differently. This ties in with Bleuler’s argument that schizophrenia is not a single illness but a group of related disorders.

**Signs and Symptoms of Schizophrenia**

Clinicians use the DSM-IV-TR criteria to diagnose schizophrenia. The following are the criteria for diagnosis based on (APA, 2000):

A. *Characteristic symptoms*: Two or more of the following, each present for a significant portion of time during a 1-month period (or less if successfully treated):

1. Delusions
2. Hallucinations
3. Disorganised speech (e.g., frequent derailment or incoherence)
4. Grossly disorganized or catatonic behaviour
(5) Negative symptoms, i.e., affective flattening, ¹aloria, or ²avolution.

**Note:** Only one Criterion A symptom is required if delusions are bizarre or hallucinations consist of a voice keeping up a running commentary on the person’s behaviour or thoughts, or two or more voices conversing with each other.

B. *Social/occupational dysfunction:* For a significant portion of the time since the onset of the delusions, or more major areas of functioning such as work, interpersonal relations, or self-care markedly below the level achieved prior to the onset (or when the onset is in childhood or adolescence, failure to achieve expected level of interpersonal, academic, or occupational achievement).

C. *Duration:* Continuous signs of the disturbance persist for at least 6 months. This 6-month period must include at least 1 month of symptoms (or less if successfully treated) that meet Criterion A (i.e., active-phase symptoms) and may include periods of prodromal or residual symptoms. During these prodromal or residual periods, the signs of the disturbance may be manifested by only negative symptoms or two or more symptoms listed in Criterion A present in an attenuated form (e.g., odd beliefs, unusual perceptual experiences).

D. *Schizoaffective and mood disorder exclusion.* Schizoaffective and mood disorders with psychotic features have been ruled out because either (1) no major depressive, manic, or mixed episodes have occurred concurrently with the active-phase symptoms; or (2) if mood episodes have occurred during active-phase symptoms, their total duration has been brief relative to the duration of the active and residual periods.

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¹ A feature of schizophrenia characterised by poverty of speech and or speech content, blocking, or latency of response ([www.medical-dictionary.thefreedictionary.com/aloria](http://www.medical-dictionary.thefreedictionary.com/aloria))

² A lack of interest or engagement in goal-directed behaviour ([www.merriam-webster.com/dictionary/avolution](http://www.merriam-webster.com/dictionary/avolution))
E. **Substance/general medical condition exclusion:** The disturbance is not due to the direct physiological effects of a substance (e.g., drug of abuse, a medication) or a general medical condition.

F. **Relationship to a pervasive developmental disorder:** If there is history of autistic disorder or another pervasive developmental disorder, the additional diagnosis of schizophrenia is made only if prominent delusions or hallucinations are also present for at least a month (or less if successfully treated).

Classification of longitudinal course (can be applied only after at least 1 year has elapsed since the initial onset of the active-phase symptoms):

- **Episodic with inter-episode residual symptoms** (episodes are defined by the re-emergence of prominent psychotic symptoms); also specify if: **with prominent negative symptoms.**
- **Episodic with no inter-episode residual symptoms**
- **Continuous** (prominent psychotic symptoms are present throughout the period of observation); also specify if: **with prominent negative symptoms**
- **Single episode in partial remission:** also specify if: **with prominent negative symptoms**
- **Single episode in full remission**
- **Other or unspecified pattern**

**Defining delusions**

The DSM-IV-TR (cited in Sadock and Sadock 2003, p. 512) defines delusions as “false beliefs based on incorrect inferences about external reality, which are firmly sustained despite what almost everyone else believes and despite what constitutes incontrovertible and obvious proof to the contrary”. The belief is not one ordinarily accepted by other members of the person’s culture or subculture (for example it is not an article of religious faith). When a
false belief involves a value judgment, it is regarded as a delusion only when it is so extreme as to defy credibility. Delusional conviction occurs on a continuum and can sometimes be inferred from the person’s behaviour. It is often difficult to distinguish between a delusion and an over-valued idea (in which case the individual has an unreasonable belief or idea but does not hold it firmly as is the case with a delusion). Delusions are subdivided according to their content. Some of the most common types are listed below:

**Bizarre** — A delusion that involves a phenomenon that the person’s culture would regard as totally implausible

**Delusional jealousy** — A delusion that one’s sexual partner is unfaithful

**Erotomatic** — A delusion that another person, usually of higher status, is in love with the individual

**Grandiose** — A delusion of inflated worth, power, knowledge, identity, or special relationship to a deity or famous person

**Of being controlled** — A delusion in which feelings, impulses, thoughts or actions are experienced as being under the control of some external force rather than being under one’s own control

**Of reference** — A delusion whose theme is that events, objects or other persons in one’s immediate environment have a particular and unusual significance. These delusions are usually of a negative or pejorative nature, but may also be grandiose in content. This differs from an idea of reference, in which a false belief is not as firmly held nor as fully organised into a true belief.

**Persecutory** — A delusion in which the central theme is that one (or someone to whom one is close) is being attacked, harassed, cheated, persecuted or conspired against
**Somatic**— A delusion whose main content pertains to the appearance or functioning of one’s body

**Thought broadcasting**— The delusion that one’s thoughts are being broadcast out loud so they can be perceived by others

**Thought insertion**— The delusion that certain of one’s thoughts are not one’s own, but rather inserted into one’s mind

**Defining hallucinations**

According to DSM-IV-TR, “hallucinations are distortions of perception.” Hallucinations may occur in any sensory modality, (e.g., auditory, visual, olfactory, gustatory and tactile), but auditory hallucinations are by far the most common. Auditory hallucinations are usually experienced as voices, whether familiar or unfamiliar, which are perceived as distinct from the person’s own thoughts. Certain types of auditory hallucinations (i.e., two or more voices conversing with one another or voices maintaining a running commentary on the person’s thoughts or behaviour) have been considered to be particularly characteristic of schizophrenia. The hallucinations must occur in the context of a clear sensorium; those that occur while falling asleep (hypnagogic) or waking up (hypnopompic) are considered to be within the range of normal experience. Isolated experiences that lack the quality of an external percept (e.g., a humming in one’s head) are also not considered hallucinations characteristic of schizophrenia. Hallucinations may also be a normal part of a religious experience in certain contexts.

Delusions are defined by the DSM-IV-TR as false beliefs, and hallucinations as false perceptions (Mohr & Pfeifer, 2009). Frith (2005) states that the basic mechanism of a
hallucination lies in the incapacity to differentiate the internal from the external source of action, hence people feel that they cannot control their own actions. Hemsley (1993) adds that hallucinations originate from confusion between memory and perception, and this results in the individual being unable to differentiate essential elements from accessory elements in a situation. Slade and Bentall (Mohr & Pfeifer 2009, p. 88) name five factors which are required to produce a false perception: “stressful events, cognitive deficits, external stimuli, reinforcement by the reduction of emotional tension, and expectancies (the subjects hallucinate what they know)”.

The most common type of hallucination is reported (Mohr & Pfeifer 2009) to be auditory, and about 60% of patients of patients with schizophrenia experience auditory hallucinations. However, most people experiencing minor hallucinations have no psychiatric disorder and do not need psychiatric treatment. Romme and Esher (Mohr & Pfeifer, 2009) explain the difference between voice-hearing non-patients and patients: Non-patients (i.e., those without a psychiatric disorder) feel their experiences as mainly positive, whereas patients are scared, upset and disrupted in their daily lives by the voices. For patients, the voices present a social-emotional problem that they are not able to solve; this leads to emotional distress, social isolation and behavioural problems. Chadwick and Birchwood (1994) point out that the person gives meaning to his or her hallucinations, which results in emotional and behavioural reactions. What causes despair and maladjusted behaviour is a dysfunctional meaning attributed to the voices in terms of malevolence and omnipotence.

Causes of Schizophrenia

Voltaire in 1764 wrote that a “a lunatic is a sick man whose brain is in bad health, just as the man who has gout is a sick man who has pains in his hands and feet… people have
gout in the brain as in the feet” (Torrey, 1995, p. 142). According to Torrey, insanity continued to be widely regarded as a brain disease throughout the 19th century. For example, Wilhelm Griesinger, who was a respected psychiatrist of the century, wrote in the 1860s that psychiatry and neuropathology are not only closely related but in fact one field in which only one language is spoken and the same laws rule. The view that schizophrenia is a brain disease is based on studies which yielded the findings outlined below.

**Neurobiology**

**Dopamine and other neurochemicals**

The simplest formulation of the dopamine hypothesis of schizophrenia is that it is an outcome of too much dopaminergic activity (Sadock & Sadock, 2003). When a person is given high doses of amphetamines, a rise in dopamine levels occurs and at the same time the person develops symptoms resembling schizophrenia. L-dopa, a drug which the body may convert to dopamine, makes the symptoms of schizophrenia worse if given to someone who has been diagnosed with schizophrenia. Drugs that are effective in treating schizophrenia block the dopamine action. Serotonin, norepinephrine, gaba, glutamine and neuropeptides are some of the neurotransmitters which have been found to show abnormal levels in people diagnosed with schizophrenia.

**Neuropathology**

During the 19th century, neuropathologists identified neuropathological changes in the brains of patients with schizophrenia. Magnetic Resonance Imaging (MRI) was introduced in the 1980s, using radio waves to produce images of the brain, and has proved to be of great benefit for schizophrenia research. This technology has enabled the medical profession to identify clear structural abnormalities in the brain, such as mild to moderate dilatation, which
was found in individuals with schizophrenia; however, it is not specific to schizophrenia and may also be found in manic-depressive psychosis, brain tumours, strokes, Alzheimer’s disease and other brain diseases. Those diagnosed with schizophrenia also presented with ventricular dilatation (Torrey, 1998). Sadock and Sadock (2003) further point out that studies on affected twins show that almost all the affected twins had larger cerebral ventricles than their non-affected twins; although some of the ventricles of affected twins were normal. Torrey (1998) and Sadock and Sadock (2003) note that there is generalised atrophy of the hippocampus and the amygdala in patients who have been diagnosed with schizophrenia. This loss of brain tissue is perceived as being minimal; however, it is assumed to be part of the disease process.

Microscopic studies of post-mortem brain tissue of people who have been diagnosed with schizophrenia have shown evidence of abnormalities. Most of these changes in the brain tissues suggested a decrease in the number of neurons in areas like the hippocampus, entorhinal cortex, cingulate cortex, prefrontal cortex, motor cortex and the thalamus (Arnold & Rioux, 2001; Buchsbaum, 1990; Petronis, Patterson & Kennedy, 1999; Torrey, 1998). This seems to be consistent with the MRI that showed atrophy of the hippocampus.

**Genetic Factors**

Genetic theories of schizophrenia are among the oldest and most extensively tested. These theories claim that schizophrenia is inherited. Studies of identical twins show that when one twin develops schizophrenia, the second twin has an approximately 30% chance of being affected (Torrey, 1998). Sadock and Sadock (2003) stress that since the application of the techniques of molecular biology became widespread; many associations between chromosomal sites and schizophrenia have been reported. Sadock and Sadock further conclude that there is a potentially heterogeneous genetic basis for schizophrenia. However,
there is a debate regarding the role that genes play in the development of schizophrenia. Bernheim and Lewine (1979) argue that, while the case for the genetic transmission of schizophrenia is a solid one, it by no means accounts for all cases of schizophrenia and roughly 90% of persons diagnosed with schizophrenia do not have a parent with the illness.

Behavioural geneticists have stressed that the fact that the concordance rate for schizophrenia is far from 100% in many studies is the best single piece of evidence pointing to the importance of environmental factors (Bernheim & Lewine, 1979). If the disease is truly genetically transmitted, it does not fit the recessive or dominant patterns. An alternative explanation could be that schizophrenia is not a genetic disease as such, but rather involves a genetic predisposition to the causative agent (Torrey, 1998). Bernheim and Lewine (1979) argue that while genetic transmission may determine a schizophrenic predisposition, whether or not a person ultimately exhibits gross psychotic behaviour depends on environmental factors. This is consistent with the stress-diathesis model of schizophrenia. Sadock and Sadock (2003) indicate that the basic assumption of this model is that the integration of the biological, psychosocial, and environmental factors imposes a certain vulnerability on the individual. When an individual is exposed to a stressful event, therefore, schizophrenia may develop.

**Developmental Defects**

The idea that schizophrenia has its origins in early development dates back at least to the modern classification of the syndrome by Emil Kraepelin and Eugen Bleuler, both of whom noted abnormal neurological and behavioural signs in the childhood histories of adult patients (Weinberger & Levitt, 2011). Weinberger and Levitt further argue that developmental abnormalities, which may be due to random processes, genetic or
environmental factors, have the potential to change the structure of the brain circuits and connectivity. This, according to the above authors, could possibly contribute towards further abnormalities of the brain’s circuitry. Therefore, the chances of schizophrenia developing in early adult life are higher (Weinberger & Levitt, 2011). The developmental theory assumes that any one of a number of agents could cause the defect if that agent affected the brain at a critical stage of development in utero or shortly after birth (Torrey, 1998).

Torrey (1998, p. 154) discusses the following presentations which point to the earliest months of life as being the time when the initial brain damage occurs in some cases of schizophrenia:

1. Minor physical anomalies. These are nonobvious but measurable physical deviations of the head, hands and feet. Examples are low-set ears, a high arched palate, curved fifth finger and a wide space between the first and second toes. These anomalies may be found in normal persons but they are found more frequently in individuals with various kinds of brain dysfunctions. Additional studies have reported the same finding for childhood-onset schizophrenia.

2. Fingerprint patterns. Differences in fingerprint patterns have been observed in a variety of diseases, including schizophrenia. Since the 1930s, studies have shown that individuals with schizophrenia differ slightly in their fingerprint patterns from the normal controls.

3. Pregnancy and birth complications. Studies have shown a correlation between pregnancy and birth complications, and schizophrenia. It is significant to emphasize that not all women with pregnancy and birth complications give birth to children who will develop schizophrenia; it should be noted, however, that both the observable complications and schizophrenia may have been caused by non-observable events such as an in utero infection.
4. Seasonality of births. Most people diagnosed with schizophrenia are born in winter and early spring months. This is only a statistical association and is not predictive for any individual. Other studies point out that seasonal excess of birth in schizophrenia is not an artefact but real and can be theoretically explained by infectious agents, nutritional factors, temperature, or other seasonal environmental variables.

5. Microscopic studies of the brain. Many of the microscopic studies that report abnormalities in brain structure show abnormalities in the number and arrangement of brain cells which could have taken place during the development of the brain.

In addition, Torrey (1998) indicates that schizophrenia is firmly established as a brain disease just as undisputably as multiple sclerosis, Parkinson’s disease and Alzheimer’s disease. The above description of aberrations found in utero points to the possibility that brain damage may occur.

**Viruses**

Viruses are known to attack very specific areas of the brain while leaving others untouched; they may also alter the functioning of the brain without altering its structure. However, the evidence supporting viruses as a cause of schizophrenia is circumstantial (Torrey, 1998). Studies in Finland, Denmark and England have shown that women who were exposed to the influenza virus in the middle three months of pregnancy are more likely to give birth to children who later develop schizophrenia. Since viruses are seasonal, they could be related to the seasonality of births in schizophrenia. In utero exposure to influenza has been implicated as a risk factor since a report that an increased proportion of adult schizophrenia in Helsinki was associated with presumed second trimester in utero exposure to the 1957 A2 influenza epidemic (Jablensky, Kirkbride & Jones, 2011).
Management of Schizophrenia

Sadock and Sadock (2003) maintain that managing schizophrenia may begin with hospitalisation, depending on the severity of the initial presentation of the illness. During the acute stage, hospitalisation is deemed a necessary step, as it allows clinicians to stabilise the patient and perform other diagnostic assessments. First and Tasman (2006) indicate that, as schizophrenia is easily misdiagnosed and confused with other psychotic mental illnesses, it is crucial that a proper diagnosis be made. It is during this period that the family are faced with the reality that their loved one has a schizophrenia diagnosis, and support to the family is of paramount importance (Martens, 1998). Sadock and Sadock (2003) add that hospitalisation may be useful as it allows the patient to deal with the initial shock and stress. Maxmen and Ward (1995) further point out that as schizophrenia is a chronic illness, some patients need re-hospitalisation due either to non-compliance or to difficulties in controlling the severity of the psychotic episodes.

Biological therapies are initiated after a diagnosis of schizophrenia has been made. Sadock and Sadock (2003) indicate that, since the 1950s, antipsychotic medications have revolutionised the treatment of schizophrenia. The drugs used fall into two categories: the dopamine receptor agonists like haloperidol and chlorpromazine; the Serotonin-Dopamine Antagonists like risperidone and clozapine. Other drugs include anticonvulsants, lithium and benzodiazepines.

As it has been suggested that schizophrenia is a complex illness that often requires complex interventions, other treatment modalities have been shown to be effective in the management of the illness. These include psychosocial therapies, among which psychotherapy is paramount (Sadock & Sadock, 2003). Several studies on families of patients
with schizophrenia have revealed that the emotional climate at home contributes towards the wellbeing of those diagnosed with schizophrenia (Martens, 1998). The emotional climate that is felt in these families is called *expressed emotion* (EE); the concept was first introduced by Brown, Birley and Wing (1972). According to Sadock and Sadock, families with high EE present with overt criticism, hostility and over-involvement with the person with schizophrenia. This has been shown to increase the relapse rate for schizophrenia. Therefore, part of psychotherapy with these families is exploring the family’s emotional climate and discussing alternative ways of coping. Family-oriented therapies are therefore recommended to assist both the family and the person with schizophrenia (Sadock & Sadock, 2003). Social skills training and vocational therapies also form part of non-biological management of schizophrenia.

**Summary**

It is evident from the preceding discussion that there are many biomedical theories that claim to explain what causes schizophrenia. This chapter presented a historical examination of the concept and showed that there is no change regarding the explanation of schizophrenia; the historical overview shows that the more things change, the more they stay the same. Advances have been made in terms of medicating people diagnosed with the illness; however, the debate about the causes of schizophrenia continues. The next chapter examines the psychological theories of schizophrenia.
The sick individual finds himself at home with all other similarly sick individuals. The whole culture is geared to this kind of pathology. The result is that the average individual does not experience the separateness and isolation the fully schizophrenic person feels. He feels at ease among those who suffer from the same deformation; in fact, it is the fully sane person who feels isolated in the insane society—and he may suffer so much from the incapacity to communicate that it is he who may become psychotic.

Erich Fromm, The Anatomy of Human Destructiveness (1973)
Chapter 5

Psychological Theories of Schizophrenia

The debate over whether schizophrenia is an inherited disease has been going on for many years and reflects the nature-nurture controversy (Shapiro, 1981). This chapter will discuss the different theories of schizophrenia. The psychoanalytic formulation of schizophrenia comprises the study of precipitating events and their dynamic meanings, especially where these meanings are harmful more on account of their symbolic overtones than their actual threat to the individual. There are many writers who have contributed towards the psychoanalytic understanding of schizophrenia; hence, in this chapter, Freud, Melanie Klein and Margaret Mahler will be discussed. The family-theory perspective of schizophrenia will follow, including the works of Lidz, Bowen, Bateson and co-workers Laing and Wynne. The double bind theory of schizophrenia, which was formulated by Bateson and his co-workers, will be discussed as well. Lastly, the General Systems Theory will also be examined.

Psychoanalytic Theories of Schizophrenia

The psychodynamic view of human behaviour explains mental disorder in terms of individual psychological energy; emphasis is placed upon human motivations, instinctual drives and unconscious forces (Bernheim & Lewine, 1979). Individual development requires moving from a state of uninhibited needs and absence of distinction between self and others to one in which gratification can be postponed and basic drives such as sex and aggression are channelled into socially accepted forms. Therefore, schizophrenia in this framework is explained as “a return to a less developed state in which the part of us that copes with reality is not functioning properly and the person is overwhelmed with infantile thoughts, feelings and drives” (Bernheim & Lewine, 1979, p. 110).
Although Freud was not primarily concerned with schizophrenia, he offered three partial theories and initiated several conflicting trains of thought on the subject (Shapiro, 1981). His work on the unconscious, dreams, the meaning of neurotic symptoms and the structure of the mind laid the foundation for future psychoanalytic enquiries into schizophrenia. Freud hypothesised that schizophrenia occurred as a result of developmental fixations that took place earlier than those culminating in neuroses (Sadock & Sadock, 2003). He (Freud) later suggested that, whereas in neurosis the ego makes compromises between wishes and the dictates of reality and of the superego, the schizophrenic ego is uncompromising and denies reality (Robbins, 1993). He concluded that “what occurs in all such cases of [of schizophrenia] is a split in the mind. Two mental attitudes have been formed instead of a single one, the normal one, which takes account of reality, and another which under the influence of the instincts detaches the ego from reality” (Robbins, 1993, p. 138). Shapiro (1981) adds that, in terms of Freud’s view, the schizophrenic’s thought disorder results from the ego’s defending itself against reality by rejecting both the idea and affect and then behaving as if the idea never occurred to it; denying a piece of reality. The schizophrenic withdraws not only from the external world but from the unconscious representation of it as well. The neurotic, on the other hand, represses the idea, which then emerges in a fantasy (Shapiro, 1981).

**Melanie Klein**

Melanie Klein accepted Freud’s implicit challenge that aggression must be central to the expanded psychoanalytic theory, not sexuality. She emphasised the neurotic or conflict-defence model of normal development and of schizophrenia, a model based on the splitting of the ego and projective identification in defence against the postulated death instinct. Klein
also highlighted the importance of dyadic relationships and the role of integration and
differentiation in development (Goldstein, 1978; Robbins, 1993).

The Kleinians believe that sufficient ego exists at birth to experience anxiety, to use
defence mechanisms and to form primitive object relations in phantasy and reality (Goldstein,
1978). Goldstein further explains that the immature ego at birth is exposed to anxiety stirred
up by the conflict between the life instincts and the death instincts. It is this relationship of
the immature ego to these instincts at birth that characterises the first 6 months of life; this is
called the paranoid-schizoid position. During this stage, the whole idea is for the immature
ego to get rid of the death instincts (the bad objects) and to retain the life instincts (the good
objects). The leading anxiety of the paranoid-schizoid position is that the persecutory object
(bad object, death instincts) will get inside the ego and overwhelm and annihilate the ideal
(good) object and self. The mechanisms of defence of introjection, projection, splitting,
primitive idealisation, denial and projective and introjective identification are used to get rid
of this anxiety. When these defences fail to mask this anxiety, disintegration, fragmentation
and splitting into bits or fragments may take place in the ego and damage it. This happens
when there is too much death instinct or the infant cannot keep the death instinct away from
the ego because of predominance of bad experience over good in the first six months. When
this occurs, the basis for the development of schizophrenia is formed (Goldstein, 1978).
Goldstein, unlike Freud, further points out that schizophrenics are certainly seen as capable of
forming transference. It is the emphasis on aggression in schizophrenia, the description of the
primitive defences, and the idea that schizophrenics can indeed form transference that stand
out as major contributions by the Kleinians to the conception of schizophrenia beyond Freud.
Margaret Mahler

Goldstein (1978) describes Mahler’s early object relations theory as follows: During the first year of life, Mahler suggests that the child goes through an autistic phase (of approximately 1 month) during which he is oblivious to anything except himself, followed by a symbiotic phase (up to around 5 to 10 months) in which he views his mother (or primary love object) as an extension of himself. This is followed by a separation-individuation phase (lasting up to age 2 or 3) in which the child very gradually differentiates and separates himself from the mother and begins to establish his identity as a person in his own right. The autistic and symbiotic phases are similar to Freud’s auto-erotic and narcissistic phases. Mahler’s emphasis is on the child as his personality unfolds in relation to his mother. Mahler argues that the early interaction between mother and child during the autistic and symbiotic stages is crucial in determining whether an individual would become schizophrenic.

Mahler’s concept of symbiosis represents the dyadic relationship paradigm that is central to normal infant development. In a symbiotic relationship, at least one of the partners is, and at times both are, unable to function well without the other; the other performs mental and at times physical functions that the other is unable to (Robbins, 1993). The disturbance occurs due to distortions in the reciprocal relationship between the mother and the infant in which the child is unable to separate from, and progress beyond, the closeness and complete dependence that characterise the mother-child relationship in the oral phase of development (Sadock & Sadock, 2003).

Robbins (1993) argues that not all psychoanalytic contributions to schizophrenia can trace their lineage to Freud. Harry Stack Sullivan (Robbins, 1993), the foremost supporter of
psychotherapy for schizophrenia, proposed what he called the interpersonal theory. Sullivan states that “the infant is not a cauldron of libidinal drives and constitutional phylogenetic propensities, but a tabula rasa, impinged upon by an overanxious mother when he manifests oral dynamics” (p. 141). Sadock and Sadock (2003) are of the opinion that the source of pathological anxiety results from cumulative experimental traumas during development. According to Sullivan (Sadock & Sadock, 2003), schizophrenia is an adaptive method used to avoid panic, terror and disintegration of the sense of self.

A particularly important developmental period in relation to schizophrenia is adolescence. It is a time of turbulence, instability, the trying of various roles, the breaking away from the family and an attempt to discover one’s true sense of self (Bernheim & Lewine, 1979). The onset of symptoms during adolescence occurs “when teenagers need a strong ego to function independently, to separate from the parents, to identify tasks, to control increased internal drives and to cope with intense internal stimuli” (Sadock & Sadock, 2003, p. 483). The adolescent, therefore, is caught in a bind between the desire for independence and the desire for dependence (Bernheim & Lewine, 1979).

Regardless of the theoretical model, all the psychodynamic approaches are founded on the premise that psychotic symptoms have meaning in schizophrenia. For example, patients may become grandiose after an injury to their self-esteem (Sadock & Sadock, 2003).

The Family-Theory Perspective of Schizophrenia

In the last three decades, the family approach movement in psychiatry has gathered momentum and has developed into three distinct areas: family psychiatry; family therapy and family and schizophrenia (Howells, 1991). Howells defines family psychiatry as:
…a clinical approach by which a child, an adolescent or an adult, referred from a family because of emotional disorder, is regarded as an indication of family psychopathology. This concept leads to the employment of procedures for investigating the psychodynamics of the whole family in its social and cultural setting and to offering treatment on a family basis. In family psychiatry, a family is not regarded merely as a background to be modified to help the presenting patient alone. Family psychiatry accepts the family itself as a patient, the presenting member being viewed as a sign of family psychopathology. The family itself is the therapeutic target. (p. 173).

Family therapy, on the other hand, has its origins in the work of Nathan Ackerman in New York in the 1930s; its emphasis is on psychotherapy in a family setting (Howells, 1991). Ackerman envisioned family therapy as an approach to the link between disorders of family living and the disorders of an individual family. Its basic assumption is that emotional difficulties stem from disturbances in the overall interaction of all family members.

The third element, which is family dynamics and schizophrenia, focuses on the different schools of thoughts with regard to how they conceptualise the illness. During the 1950s and 1960s, schizophrenia was a major focus of family researchers and therapists and received more attention from prominent scholars of the family than other forms of psychopathology (Goldstein & Strachan, 1987).

Theodore Lidz

Lidz, Fleck, Cornelison and their colleagues have been responsible for a number of important studies concerning abnormalities in patterns of behaviour in the families of
schizophrenic persons (Howells, 1991). According to Lidz (1973), the family is the first social system that the child knows and into which he grows; therefore, the child learns socially accepted roles of parents, sons, daughters, husbands and wives and how these roles impact upon the family and its functioning. The child learns from the family’s behaviour, value systems, role definitions and patterns of interrelating with one another. According to Lidz and Fleck (1985), one of the distinctive features of schizophrenia is the disturbed symbolic functioning. The hypothesis is that schizophrenia symptoms are an escape by the patient from an untenable world where he is unable to deal with conflicts by distorting his symbolisation of reality. Lidz and his group of co-workers at Yale argued that, in the families of schizophrenics, distortions in the role relationships between parents and between parent and child in terms of age and sex gave the child a distorted view of his or her own identity and unrealistic ideas about the outside world (Goldstein & Strachan, 1987; Robbins, 1993). This process is called transmission of irrationality. Lidz and Fleck (1985) argue that a schizophrenic withdraws through distortion of reality because he has been chronically exposed to intra-familial communications that deny and distort the obvious interpretation of the environment.

Lidz, Cornelison, Fleck and Terry (1957) describe the two major patterns of distorted parental roles: marital skew occurs when the parents have markedly distorted sex roles; the mother is dominant and distant in contrast to the husband who is passive and ineffectual. The second pattern is the marital schism which is characterised by chronic hostility and criticism between the spouses and attempts to compete for the child’s loyalty and affection.

Robbins (1993) states that skewed families raise potential male schizophrenics; beneath the superficial layer of harmony there is a mother who is seductive and domineering and a passive father. In schismatic families – the pattern associated with female
schizophrenics – the father is grandiose and seductive whilst the mother is aloof and devalued. Lidz in Robbins (1993, p. 164) mentions that “At times, the deviant or delusional ideas of one parent are accepted by the spouse and become a folie à deux, or, when shared by all family members, a folie à famille. Fleck (1960, p. 335) further explains the dynamics of schismatic families: “…these families are beset by chronic strife and controversy, primarily between the parents. The friction may focus on specific issues such as religion or the family’s social status, and these topics are constantly dragged into family discussions and interaction. Usually, however, such specific contents are only the outward symptom of a basic distrust and often hatred of one spouse for the other”. Fleck adds that the undermining and despising of each other occurring between the parents can create challenging identity problems for their offspring.

In skewed families, the marriage may be peaceful and mutually satisfactory because the spouses have overtly or covertly reached a compromise concerning a serious personality defect in one or the other. Usually, one parent has given in to the more disturbed and domineering one, but peace between them may be maintained at the expense of the children (Fleck, 1960).

Howells (1991, p. 181) gives some of the characteristics that Lidz and his colleagues formulated from their study of 17 patients in 1952:

1. failure to form a nuclear family, in that one or both parents remain primarily attached to one of his or her parents or siblings
2. family schisms due to parental strife and lack of role reciprocity
3. family skewing when one dyadic relationship within it dominates family life at the expense of the needs of other members
a blurring of generation lines in the family, as when one parent competes with children in skewed families, when one parent establishes a special bond with a child, giving substance to the schizophrenic child’s claim that he or she is more important to the parent than the spouse, and when continued eroticisation of a parent-child relationship occurs

a pervasion of the entire family atmosphere with irrational, usually paranoid ideation

the persistence of conscious incestuous preoccupation and behaviour within the group

a socio-cultural isolation of the family as a concomitant of the six preceding conditions

failure to educate toward and facilitate emancipation of the offspring from the family, a further consequence of the first five points

the handicapping of a child’s efforts to achieve sexual identity and maturity by the parents’ uncertainty about their own sex roles

the presentation to a child of prototypes for identification that are irreconcilable in a necessary process of consolidating his or her own personality

According to Lidz it is a justifiable hypothesis that schizophrenia is a type of maladaptation and mal-integration due to deficiencies in acquired instrumental techniques in ego structuring, rather than to some process that disrupts the integrative capacity of the brain (Howells, 1991).
Murray Bowen

Bowen’s view is that the schizophrenic psychosis of a patient is a symptom manifesting acute process involving a triad of the family. The family unit is regarded as a single organism, and the patient is seen as that part of the family organism through which the overt symptoms of psychosis are expressed (Howells, 1991). Bowen developed the concept of differentiation of self and undifferentiated family ego mass; a “differentiated” individual can be close to his or her family members, or to anyone else, “without fusing into an emotional oneness” (Bowen in Goldstein & Strachan, 1987, p. 486). Goldstein and Strachan add that the undifferentiated family ego mass is the poison of feeling within the family; if one family member experiences an emotion, it reverberates around the family.

Howells (1991) explains these family dynamics as follows: The subject of the mother’s concern about the patient and the focus of her picking on the patient are the same as her own feelings of inadequacy. According to Bowen, the mother can function more adequately by ascribing to her child certain aspects of herself, which the child accepts. The mother then ‘mothers’ in the child the helplessness, which is her own projected feeling, with her adequate self. Thus a situation that begins as a feeling in the mother becomes a reality in the child. The projection occurs also on the level of physical illness, a mechanism in which a soma of one person reciprocates with the psyche of another person and an anxiety in one person becomes a physical illness in another. When the child’s self is devoted to “being for the mother”, the child loses the capacity of “being for himself”. The process in which the child begins to “be for the mother” results in an arrest in the child’s psychological growth. Once free of the mother, the child faces outside relationships without a self of his or her own. The psychosis represents an unsuccessful attempt to adapt the severe psychological
impairments to the demands of adult functioning. It represents a disruption of the symbiotic attachment to the mother and a collapse of the long-term interdependent father-mother-patient triad.

Bowen’s theory of schizophrenia is multigenerational; grandparents may be mature and differentiated, one offspring becomes immature and undifferentiated and in turn marries an equally undifferentiated individual. The result of this union would be the creation of a very undifferentiated family ego mass, from which one or more of the children would be unable to escape and therefore would become schizophrenic (Goldstein & Strachan, 1987). Bowen regards schizophrenia as a process that requires three generations or more to develop (Howells, 1991).

**Bateson and co-workers**

Gregory Bateson headed a highly productive research group at the Palo Alto Veterans Administration Hospital, which included Don Jackson, Jay Haley, Paul Watzlawick and John Weakland. They initially wanted to understand communication in terms of multiple levels of meaning (Goldstein & Strachan, 1987). They used Russell’s theory of logical types which proposed that all messages are accompanied by a statement about the message, or a meta-message at a higher level.

**The Double Bind Theory of Schizophrenia**

Bateson, Jackson, Haley and Weakland introduced the concept of double bind to describe a combination of suppression of autonomy and shared denial that forces the child to remain pathologically dependent (Robbins, 1993). According to Robbins, disability and undifferentiation are rewarded and there are subtle threats of attack and rejection of the
schizophrenic member should he use his mind and sense of reality to attempt to achieve a
degree of differentiation and autonomy.

The double bind theory views schizophrenia as an appropriate response to mixed
messages. The contradictory messages occur at two different levels of communication.
Bateson and his colleagues describe the necessary ingredients of a double bind situation in
Howells (1991, p. 182):

(1) Two or more persons. Of these, we designate one, for the purpose of our
definition, as the “victim”. We do not assume that the double bind is inflicted by the
mother alone, but that it may be done either by the mother, father and or siblings.
(2) Repeated experience. We assume that the double bind is a recurrent theme in the
experience of the victim. Our hypothesis does not invoke a single traumatic
experience, but such repeated experience that the double bind structure comes to be a
habitual expectation.
(3) A primary negative injunction. This may have either of two forms: (a) “do not do
so and so, or I will punish you”; (b) “if you do not do so and so, I will punish you”.
Here we select a context of learning based on avoidance of punishment rather the
context of reward seeking. We assume that the punishment may be either the
withdrawal of love or the expression of hate or anger or — most devastating — the
kind of abandonment that results from the parent’s expression of extreme
helplessness.
(4) A secondary injunction conflicting with the first at a more abstract level, and, like
the first, enforced by punishments or signals which threaten survival. This secondary
injunction is more difficult to describe than the primary for two reasons. First, the
secondary injunction is commonly communicated to the child by nonverbal means.
Posture, gesture, tone of voice, meaningful action, and the implications concealed in verbal comment may all be used to convey this abstract message. Second, the secondary injunction may impinge upon any element of the primary prohibition. Verbalisation of the secondary injunction may, therefore, include a wide variety of forms, for example, “Do not see this as punishment”; “Do not see me as the punishing agent”; “Do not submit to my prohibitions”; “Do not think of what you must not do”; “Do not question my love of which the primary prohibition is (or is not) an example”; and so on. Other examples become possible when the double bind is inflicted not by one individual but by two. For example, one parent may negate at a more abstract level the injunction of the other.

(5) A tertiary negative injunction prohibiting the victim from escaping from the field. In a formal sense, it is perhaps unnecessary to list this injunction as a separate item since the reinforcement at the other two levels involves a threat to survival, and if the double binds are imposed during infancy, escape is naturally impossible. However, it seems that in some cases the escape from the field is made impossible by certain devices which are not purely negative, e.g., capricious promises of love and the like.

(6) Finally, the complete set of ingredients is no longer necessary when the victim has learned to perceive his universe in double bind patterns. Almost any part of a double bind sequence may then be sufficient to precipitate panic or rage. The pattern of conflicting injunctions may even be taken over by hallucinatory voices.

Bateson and his colleagues further explain the general characteristics of this double bind as follows: (1) When an individual is involved in an intense relationship; that is, a relationship in which he feels it is vitally important that he discriminate accurately what sort of message is being communicated so that he may respond appropriately. (2) And, when the
individual is caught in a situation in which the other person is expressing two orders of messages and one of these denies the other. (3) And, when the individual is unable to comment on the messages being expressed to correct his discrimination of what order to respond to… (Shuham, 1967, p. 411). Robbins (1993), furthermore, indicates that the most destructive element of the double bind is the unspoken injunction that the contradictions are to be denied and not talked about.

**Lyman Wynne and Margaret Singer**

Wynne and his colleagues concentrated mainly on schizophrenic illness in which the onset of psychosis occurred acutely in late adolescence or early adulthood. They considered that the universal necessity for dealing with both the problems of relation and identity leads to three main solutions: mutuality, non-mutuality and pseudo-mutuality (Howells, 1991). Howells further explains these concepts: Each person brings to the relations of genuine mutuality a sense of his or her own meaningful, positively valued identity. Out of the experience of participation together, mutual recognition of identity develops, including a growing recognition of each other’s potentials and capacities.

Most interpersonal relationships are characterised by non-mutuality, which is the interaction between two people where the two parties are not invested in the relationship and there is no necessity of exploring what the relationship has to offer to either person. For example, the relationship between the salesperson and the customer ends after the purchase is made.

The concept pseudo-mutuality was coined by Wynne and Singer to describe the use of shared denial to conceal irreconcilable conflict and related failures of communication (Robbins, 1993). In pseudo-mutuality, emotional investment is directed more toward
maintaining the sense of reciprocal fulfilment of expectations than toward accurately perceiving changing expectations. The relation that persists cannot be given up, except under very special circumstances, nor be allowed to develop or expand. Therefore, the pseudo-mutual relation involves a characteristic dilemma; divergence is perceived as leading to disruption of the relation, and therefore must be avoided. However, if divergence is avoided, growth of the relation is impossible. In the families of potential schizophrenic persons, the intensity and duration of pseudo-mutuality leads to the development of a particular variety of shared family mechanisms by which deviations from the family role structure are excluded from recognition or delusionally reinterpreted. Pseudo-mutuality is maintained at all costs which leads to maintenance of stereotyped roles in the families of schizophrenic persons; these roles in turn constrict identity development and contribute to serious crises, including psychosis. Acute schizophrenic panic or disorganisation seems to represent an identity crisis in the face of overwhelming guilt and anxiety attendant on moving out of a particular kind of family role structure.

Wynne and his colleagues believed that fragmentation of experience, the identity diffusion, the disturbed modes of perception and communication and certain other characteristics of the acute reactive schizophrenic personality structure are derived by a process of internalisation from characteristics of family social organisation (Singer & Wynne, 1965).

Wynne and Singer argued that a necessary condition for communicating is a shared focus of attention that can lead to shared meanings (Goldstein & Strachan, 1987). The two formulated the concept of *communication deviance*, in which the listener is unable to construct a consistent visual image or a consistent construct from the speaker’s words.
Goldstein (1985) further adds that parental deviance has been found to be a successful predictor of the schizophrenia-spectrum disorders in a longitudinal high risk design.

The above three groups followed the model that schizophrenia was a communication disorder and this disorder was caused by distorted and confusing patterns of parental communication. As the systemic perspective emerged, these groups started observing families of schizophrenics during psychiatric interviews (Hoffman in Goldstein & Strachan, 1987). The use of systemic concepts became the norm in describing families; Jackson (1957), for example, describes these families as closed systems with homeostatic mechanisms that maintain the system through positive feedback.

This discussion of the family perspective of schizophrenia is concluded with a statement by Howells (1991) that the family psychopathology has causal significance for schizophrenia but also that the presence of schizophrenia causes family psychopathology. He argued that since schizophrenia is such a severe and puzzling disorder, it would be surprising if the state of the family was not affected by the disorder. Especially in the case of childhood schizophrenia where the parents have to endure the puzzling symptoms of schizophrenia, the family organisation and functioning will change to adapt to the child’s behaviour. The next section presents the General Systems Theory; this theory adds to the family systems understanding of schizophrenia.

**The General Systems Theory**

The struggle to reconcile the psychosocial and the biological perspectives in medicine was dominated by the reductionist approach of molecular biology. As early as 1928, Ludwig Von Bertalanffy first introduced a series of concepts which were intended to provide the basis for an organismic approach to biology; he believed that certain fundamentally important
questions in biological science required a new and different approach (Steinglass, 1987). The General Systems Theory (GST) was developed due to the dissatisfaction with the traditional reductionist-mechanistic approaches and the linear cause-and-effect theories that explained growth and change in living organisms (Friedman & Neuman Allen, 2011). The biologist Ludwig von Bertalanffy is credited with formulating GST in 1936 (Held, 2000).

There are different definitions of systems; the ones that follow are those that resonate well with the basic assumptions of GST: Bertalanffy defined a system as “sets of elements standing in interaction”, and he set the goal of GST as the search for “those principles which are valid for ‘systems’ in general” (Held, 2000, p. 457). Gregory Bateson described the system as “...any unit containing feedback structure and therefore competent to process information” (Bateson, 1971, p. 243). Rapaport defines the system as an entity that can maintain some organization in the face of change from within and without. According to Ackerman (1985) change of behaviour in one entity affects behaviours of all other entities in the family system.

GST suggests that the study of systems requires an understanding of the dynamics of the whole rather than a reductionist analysis of parts. It implies a focus on the relationship between the components of a system and the relationship between the system and its contextual environment rather than a focus on the components themselves (Kossman & Bullrich, 1997). Becvar and Becvar (2003) state that the whole is greater than the sum of its parts, which means that no complex system can be fully understood if one adopts a strategy of breaking it down into its component and subcomponent parts. Instead, it has its uniqueness, an additional element, that is a product of the intricate structural and functional integration of these parts into a unified whole.
The goal of GST is to find the “organizing relationships that result from dynamic interaction and make the behaviour of parts different when studied in isolation than when studied within the whole” (Held, 2000, p. 457). James Miller (cited in Held, 2000) similarly argues that the state of each element in the system is determined by the state of the other elements in that system. This is also echoed by Gregory Bateson’s expression, “the pattern which connects,” a phrase used by many family systemstheorists and therapists in the 1980s (Held, 2000). Steinglass (1987) maintains that neither pathology nor treatment should be explored in the absence of a sophisticated understanding of this uniqueness.

GST suggests that specific disciplines of science can be transcended, in a sense, by focusing on the process of systems rather than the specific content studied (Kossman & Bullrich, 1997). In his essays “The Need for a New Medical Model: A challenge for Biomedicine”, Engel explored the relative utility of the traditional model of disease, which limits itself to somatic parameters, as contrasted to the “new model that attempts to incorporate psychosocial parameters as well” (Steinglass, 1987, p.29).

Jacob (1987) maintains that the GST approach focuses on interaction between elements in a system, those patterns of interactions that serve to make possible and to sustain complexity and constancy of systemic organisation and function. Steinglass (1987) adds that the systemic approach is beneficial to clinicians for two reasons: first, because in many instances an adequate appreciation of pathology is best achieved within the context of a knowledge of the systemic properties of the organism under study; and second, because efficient treatment of pathology is best planned if one keeps in mind the effect of various interventions on the organism as a system. Steinglass further states that correction of pathology in one part of the system may overtly correct the presenting complaint, but only at the expense of a fundamental distortion of the organism’s natural architecture and functional
integrity. Therefore, only focusing on medication for individuals with schizophrenia, without exploring and addressing relational issues or the interactions that occur between the patient and their immediate family and the community (which includes the church and the work or school environment), may only provide short-term alleviation of symptoms.

Furthermore, instead of assuming that behaviour is the product of a linear causal chain of factors and events, behaviour should be seen as a product of the various interactive relationships and organisational characteristics of the family as a whole (Becvar & Becvar, 2003; Robbins, 1993; Steinglass, 1987). Jacob (1987, p.11) has this to say about the core concepts of family systems theory: “Most important, the distinction between open and closed systems reminds us that families (as open systems) maintain their constancy through a continuous exchange and flow of information; that is, the identity and functioning of an open system depend on communication within the system and between the system and the external environment”. Theodore Jacob explains further how the above-mentioned concept brings about a series of operating principles and developmental processes that characterise any open system, including the family (p.11):

1. **Constancy** is achieved through continuous communication within the family and between the family and the external environment
2. **Adaptiveness and change** can occur in response to the fluctuating internal and external environment
3. **Order and organization** are not only possible but are expected to occur over time
4. **Subsystems, boundaries and their permeability** serve to differentiate the family system and to define the nature of relationships within the family and the external environment
5 *equifinality* informs us that the same final state can be reached from different initial conditions and as a result directs attention from the one-cause-one-effect models and toward different developmental pathways.

6 *positive and negative feedback processes* enable the investigator to approach questions on how change occurs and how sameness remains.

Engel (1984) finally adds that when a general systems approach becomes part of the basic scientific and philosophic education of future physicians and medical scientists, a greater readiness to encompass a bio-psycho-social perspective of disease may be anticipated.

**Summary**

This chapter explored the psychological theories of schizophrenia, and an attempt was made to explain schizophrenia from the psychological point of view. This chapter highlights the importance of relationships and how a distortion in the way we relate can potentially lead to the emergence of schizophrenia. The family is described as a system, and dynamics that play out in different families that may cause schizophrenia are examined. The next chapter discusses mental illness and culture.
We are hollow men
We are the stuffed men
Leaning together
Headpiece filled with straw. Alas!
Our dried voices, when
We whisper together
Are quite and meaningless
As wind in dry grass
Or rats’ feet over broken glass
In our dry cellar
Shape without form, shade without colour,
Paralysed force, gesture without motion;
Those which crossed
With direct eyes, to death’s other kingdom
Remember us—if at all—not as lost
Violent souls, but only
As the hollow men
The stuffed men.

--T.S.Eliot, “The Hollow Men” (1925)
Chapter 6

Mental Illness and Culture

This chapter examines the importance of culture in mental health. Cultural meaning systems shape the experience of self through the construction of cultural schemas, and they structure the physical and social environment (Castillo, 1997). The old adage that says “madness is as madness looks” suggests a deep rooted concern with knowing who the mad are; it also indicates a complex relationship between madness and culture that has deep historical roots (Cross, 2010, p. 129). Firstly, the concept of culture will be defined. The following issues are also explored: a comprehensive discussion of culture-bound syndromes; African culture and mental illness; and traditional healers and their view of mental illness.

Defining Culture

In an attempt to deal with the chaos and confusion regarding the definition of culture, Geertz made a nominal definition of the concept. This means that he defined it based on the context in which it was being used. Nominal definitions are evaluated not in terms of correctness or precision, but in terms of usefulness for particular purposes (Rice, 1980).

Geertz’s contextual (nominal) definition of culture incorporated the following elements in most of its descriptions (Rice 1980, p. 30), in which culture is defined as:

1. An ordered system of meaning and symbols in which social interaction takes place
2. The framework of beliefs, expressive symbols and values in terms of which individuals define their world, express their feelings and make judgments
3. The fabric of meaning in terms of which human beings interpret their experience and guide their action
4. Systems of interacting symbols and patterns of interworking meanings
A system of inherited conceptions expressed in symbolic forms by means of which men communicate, perpetuate and develop their knowledge about and attitudes towards life.

**Impact of Culture on Mental Health**

Jenkins and Barret (2004) explain culture as shared symbols and meanings that people create in the process of social interaction. “Culture shapes experience, interpretation and action thereby orientating people in their ways of feeling, thinking, and being in their world” (Jenkins & Barret, 2004). Obeyesekere (1990) expresses the work of culture as transformation and formation whereby symbolic forms existing on the cultural level are created and recreated through the minds of the people. Obeyesekere further asserts that schizophrenia is a work of culture through which unconscious motives are transferred onto cultural symbols. All cultures define a spectrum of ‘normal behaviours’ as well as thresholds of tolerance for diverse ‘abnormalities’, imposing different social consequences on different patterns of deviance (Sadock & Sadock, 2003).

Western biomedical models of psychiatry are unusual in terms of world cultures; they suggest a strict separation between parts of the self, determined as mind, body and spirit. In this frame, health and illness are seen in terms of physical phenomena, which can only be treated by medical expertise (Parle, 2007). Parle further argues that if sufficiently contextualised and defined, the concept of mental illness and mental health are useful ones in that they are shorthand expressions, now widely understood, of a universal human concern with illness as an area of problematic human experience. She adds that it is important to recognise that all societies have therapeutic systems; sets of beliefs and practices designed to alleviate suffering. These systems may not all have the same definitions for illness or similar
explanatory models of the origins of the discomfort, but “all societies recognise behaviours and actions that are deviant, unacceptable or threatening, and all have concepts of normality and abnormality. It is the context of that ‘normality’ that is context and culture specific” (Parle, 2007, p. 9).

Cultural meanings attributed to schizophrenia are very often embedded in conflict between tradition and modernity, for example between witchcraft and medicine, between patient advocacy groups and psychiatric orthodoxy, or between competing religions and sects (Jenkins, 2004). According to Jenkins (2004), culture may create a stable framework of meaning that enables a person to make sense of experiences that may be bizarre and abnormal.

Some Egyptians attribute mental illness to exposure to sudden fright, possession of evil spirits, use of magic, head injuries, heredity or the evil eye (Endrawes, O’Brien & Wilkesh, 2007). Illness is also viewed by some as the result of one’s sins and is a punishment from God; others believe it is one way of healing the soul, arguing that, as a result of the mental illness, the family will return to God and pray.

Abnormal and psychopathological states of mind are intimately connected to the belief systems of the society and of the individual and the extent to which the patient has power over his own role as a sick person. Waxler (1984) states that in societies where beliefs about mental illness centre on supernatural causation, where the person is not held responsible for his illness, where his ‘self’ remains unchanged, he can shed the sick role quickly and easily. However, where psychiatric illnesses are believed to involve personality change and personal responsibility, the sick person receives many messages that something is
seriously wrong with his self; his self-perception and behaviour may conform to these messages and his illness may have a long duration.

Waxler (1984) adds that the nature of the treatment system may also contribute to the patient’s outcome. In peasant societies where treatments are highly ritualised and where practitioners are not bureaucratically organised, patients and their family retain control over illness-confirming messages and the patient may easily drop the sick role and return to normality. In Western countries, where treatment systems are both comprehensive and bureaucratic, the patient may become engulfed in this system and find little reward and little opportunity for shedding the sick role. This point of view supported the claim that individuals from developing countries with mental illness, specifically schizophrenia, had a better outcome than those from developed countries.

Burns (2009) argues against this belief and states that mortality rates for patients with schizophrenia have been shown to be higher in developing countries as compared to developed countries. Burns adds that the same conditions that give rise to increased rates of death in patients living with schizophrenia in the community are likely to contribute to poorer general health status.

The most developed and complete formulation that seeks to explain why psychiatric diseases vary in type and incidence across cultures links the incidence of mental illness to social change (Leighton cited in Waxler, 1984). Leighton further suggests that rapid social change results in disequilibrium and disintegration; when such change occurs there might be, for example, increasing poverty, high frequency of broken homes and fragmented networks of communication. These may result in alienation, unmet personal needs and higher rates of mental illness in those who cannot or do not fit into the new society. Another explanation
offered by comparative social psychiatrists for the different rates and outcomes of psychiatric
disease in primitive and modern societies is that cultures vary in terms of the amount of
deviation they tolerate (Waxler, 1984).

Lemert (1967) discusses the labelling theory, which provides concepts and hypotheses
that are useful in explaining how different cultures turn out psychiatrically ill people who
follow radically different patient careers. The theory is not interested in explaining the cause
of the mental illness but in how the society responds to and processes the sick person once
the symptoms have occurred. One of the labelling theory’s basic assumptions is that people
develop psychiatric symptoms at one time or another, yet relatively few of these people end
up in formal treatment systems and in the sick role. The theory predicts that it is the societal
response to the person with psychiatric symptoms that is the prime determinant of whether he
will remain sick and will receive treatment. Therefore, the “career” of the sick person is not
influenced by biological or social factors in his past, but by the way his family, neighbours
and mental health care providers respond to him once the symptoms develop.

Implied in labelling theory is the assumption that social responses, which are based in
the belief and treatment systems of society, will vary across cultures (Waxler, 1984).
Therefore, cross-cultural differences in treated illness rates and in the social and clinical
outcomes of the sick person may be explained in terms of differences in these social
processes. Waxler further adds that it is a common and acceptable belief that once a person
has a serious mental illness like schizophrenia, he is changed for life and that he will always
be labelled schizophrenic. Rosenhan in Waxler (1984) states that once a diagnostic label is
given to a patient, most of the patient’s normal behaviour will be reinterpreted to conform to
the expectations of deviance. Hence normal people admitted to a psychiatric ward without the
knowledge of the staff and diagnosed as schizophrenic were reported to be behaving oddly.
There is a sharp contrast between Western ideas and those of peasant societies in terms of their beliefs about the prognosis of serious mental illnesses. The expectation that mental illness is of short duration is communicated to the patient by the native treatment system (Obeyesekere, 1969). Obeyesekere found that when treating mental illnesses attributed to demonic possession, the Ceylonese exorcist ties a charmed thread around the patient’s wrist and announces that the thread is protective for a limited period, say a week or 3 months. It is understood that many illnesses go away within that period of time; if not, more elaborate and major rituals are performed and repeated announcements are made by the exorcists that the ritual itself is conclusive and that the illness is now over.

Western versus non-Western individuals attribute the causes of their mental illness differently. A study done with Hong Kong Chinese and American students revealed a tendency among the American students to give emotional reasons for physical problems, while the Chinese reported external or situational causes such as pressures related to academic concerns (Al-Issa, 1995).

Scher (1994) states that schizophrenia can be seen as essentially cultural in that it manifests as an apparently different cultural perspective from the ‘norm’ presenting both the schizophrenic and the surrounding society with a “schism” between their (culturally presumed) grounds for communication. Cuban Americans who practise a religion called Santeria believe that people can be possessed by spirits and communicate with deceased ancestors (Westen, 1996). Individuals who report this belief to Western clinicians unfamiliar with their religious beliefs can be misdiagnosed as psychotic. Therefore, diagnosis of psychiatric illness always requires knowledge of the patient’s culture or subculture. Taking the above report into consideration, the pertinent question is: Is mental illness nothing but a cultural construction? If definitions of abnormality vary with culture, can one really speak of
mental illness at all? Is mental illness simply a construct used by a society to brand and punish those who refuse to respect its norms? The next section discusses culture-bound syndromes.

**Culture-Bound Syndromes**

Culture-bound syndromes raise the general question whether the Western psychiatric classification is culture-free and could be applied to all nations and cultures (Al-Issa, 1995). This concept was first introduced in the 1960s by Pow Meng Yap. Yap recommended that the variety of terms used to describe these syndromes be replaced by the description ‘atypical culture-bound psychogenic psychosis’, which was later changed to culture-bound syndromes (Sumathipala, Siribaddana & Bhugra, 2004). The APA describes culture-bound syndromes as:

…recurrent, locality-specific patterns of aberrant behavior and troubling experience that may or may not be linked to a particular DSM-IV diagnostic category. Many of these patterns are indigenous considered to be “illnesses,” or at least afflictions, and most have local names. Culture-bound syndromes are generally limited to specific societies or culture areas and are localized, folk, diagnostic categories that frame coherent meanings for certain repetitive, patterned, and troubling sets of experiences and observations. (APA, 2000, p. 898).

These are mental illnesses that are not exclusively linked to a particular culture but rather related to a prominent cultural emphasis, or to a specific social stress situation which can become important in diverse societies at different historical periods (Jilek, 2000). Some of the terms listed are universally occurring with various somatoform symptoms known in a particular culture under a local name that designates them as appropriate for special treatment
by traditional healers (Jilek, 2001). Culture-bound syndromes were regarded as phenomena peculiar to non-Western cultures and they were often labelled “exotic psychotic syndromes” before the term was used (Arieti & Meth in Jilek, 2001).

**Amok**

This is understood as a sudden attack of mad rage in a Malay man. Malays, in general, prefer to interpret psychological problems in physical terms in order to avoid the label of mental illness and the negative connotations which accompany it. Many believe that such symptoms are indicative of the loss of “semangat” or soul substance, which makes them physically weak, resulting in confusion. Another belief in this culture relates to “angin” or the wind present in the stomach and in the nerves and blood vessels that causes hallucinations and delusions (Haque, 2008). In this state, the amok-runner blindly attacks everybody he comes across, very often injuring and killing many people before he is calmed down (Van Loon, 1927). After the attack, “when he has come to, which happens as the fever subsides, the patient very often does not remember what happened, he says he was “mata gelap” (literally, “black before the eyes”)” (Van Loon, 1927, p.435).

According to some sources, the origins of Amok actually date back to the ancient Indian warriors who entered a trance state before a battle and would fight without fear or pain. It is presumed that during Indian colonisation, this aspect of Indian culture was transferred to the Malay culture. In Malay mythology, the causes of Amok are attributed to evil spirits entering the victim’s body and making him perform such acts. Amok was first documented by Captain Cook when he travelled around the Malayan archipelagos in 1770. However, it is important to know that while the DSM-IV depicts Amok as a culture-bound syndrome, it rarely occurs in modern times (Haque, 2008).
Brain fag

A reactive disorder in adolescence characterised by anxiety and depression, ‘brain fag’ affects secondary school children in an academically competitive environment. The sufferer becomes anxious, complains of headache, burning, a crawling feeling, visual difficulties, poor memory, general physical tiredness and insomnia. This disorder is prevalent in Nigeria (Ndosi, 1995; Ola, Morakinyo & Adewuyo, 2008). Ola, Morakinyo and Adewuyo (2009) add that the somatic problems result in cognitive impairments consisting of inability to grasp the meaning of written and sometimes spoken words, inability to concentrate as well as poor retention.

According to Morakinyo (1980), students who suffered from this syndrome had a very intense drive for achievement and behind this drive was the anxiety related to the outcome of the educational programme in which the students were engaged. Patients were mostly in secondary school or university or teachers or government clerks studying in their spare time to raise their educational levels. These patients usually attribute their illnesses to the fatigue of the brain due to excessive mental work (Ola et al., 2009).

Irarata

This is a malignant form of depression which manifests among the Meru tribe of Northern Tanzania. It manifests among menopausal women as a severe reactive form of depression after the loss of a spouse through death. The woman becomes so severely depressed that the will to live is affected. These women present with anhedonia, loss of
appetite and body weight; death usually occurs within weeks or months of the spouse’s death (Ndosi, 1995).

Mori

This is a frequent morbid rage experienced by Masai warriors. The affected warrior experiences a heightened state of aggression leading to irrational acts; “the warrior progressively gets into a state of psychomotor excitement as he growls with rage, hyperventilates, trembles with wide open eyes until he froths at the mouth. When he misses his target, he is usually physically restrained lest he turn homicidal” (Ndosi, 1995, p. 89).

Kupandisha mashetani

This literally means “to raise demons in oneself”. It is a form of spirit possession which frequently occurs among coastal women in Tanzania. The affected woman, who is usually highly suggestible, becomes increasingly anxious until the anxiety reaches levels of ego disorganisation and depersonalisation. Dramatic bizarre behaviour, including shouting, inappropriate acts and hyperventilation follow (Ndosi, 1995).

Jazba

This is a dissociative state occurring in a religious context. The condition occurs usually in Muslims when reciting prayers; the prayer loses memory and mental coherence during a touching religious session and utters unintelligible speech (Ndosi, 1995).
Missing Genitals

Sijuwola (1995) explains a phenomenon which was on the increase in Nigeria; this was termed the case of missing genitals. The subject, almost invariably a man, exchanges greetings with another man or at times a woman and the greeting involves a handshake. This is followed by fear that the genitals of one of the parties have disappeared. It is claimed that the offending party has invoked supernatural forces to make the genitals disappear.

According to Maher (2005) there is a popular viewpoint in Ghana that depicts genital theft as a crime committed by individuals and groups who have magical powers or medicines that make genitals disappear. The magic is activated when a sorcerer touches, greets, or shakes the victim’s hand. Sorcerers steal genitals and then offer their distraught victims medicines to reverse the effects of their magic. Some people describe genital theft as a confidence game: one criminal steals the genitals, another provides the medicines to cure the condition and the victim is unaware that the two criminals are working together. Dzokoto and Adams (2005, p. 6) further explain this game by quoting an extract from the Ghanaian weekly newspaper People and Places:

Reports reaching [the paper] indicate that these so-called jujumen who are operating undercover “infect” innocent people with this mysterious “disease” through body contact especially by shaking hands with their victims. Soon after this, the victims allegedly experience a burning sensation and realise that their manhood have [sic] disappeared. According to the reports, whilst these innocent victims are going through this nightmarish experience, a member of the syndicate quickly approaches them claiming to know someone who could restore the manhood at an exorbitant fee.
The disorder is not limited to males only. There are three female cases reported in the Ghanaian media; affected women reported experiencing shrinking breasts, changes to their genitalia, or both. One report described a woman whose “private parts sealed.” Another report described a woman who reported that her genital organ (unspecified) was vanishing. Again, it is unclear whether references to sealing and vanishing of female genitalia represent different ways of describing the same experience or represent qualitatively distinct forms of subjective experience (Dzokoto & Adams, 2005).

Maher (2005) further describes how the genital snatching is explained in terms of local meanings and context. In rural settings, genital theft embodies the inherent discord that exists in relations between kin groups, and the threat posed to kin groups by outsiders. At a more personal level, loss of genitals amounts to loss of independence and control, and of the ability to procreate and reproduce. It threatens personal and collective identity because it robs individuals of the capacity to have offspring, and to form a family. In sum, genital theft is symbolic of the external threats to personal and collective independence and identity in West African society.

The Dhat

The word dhat comes from the Sanskrit dhatu, which means ‘metal’, elixir or constituent part of the body. It was first described by Wig in 1960 (Sumathipala et al., 2004). This is an illness seen in Indian young males and is characterised by a whitish discharge in the urine, impotence, premature ejaculation, anxiety and weakness. Semen, according to Ayurvedic texts, which date back to between the 5th and 7th centuries, is one of the seven essential elements of the body. It imparts physical and mental vigour and longevity; loss
through masturbation, nocturnal emission or urine is believed to lead to weakness (Varma & Chakrabarti, 1995; Sumathipala et al., 2004). These texts argue that food converts to blood, which converts to marrow, and the marrow eventually converts to semen. It is said that it takes 40 days for 40 drops of food to be converted to one drop of blood, 40 drops of blood to be converted to one drop of flesh, and so on. Symptoms of dhat: fatigue; weakness; anxiety; loss of appetite; guilt and sexual dysfunction due to loss of semen.

Koro

Koro or genital retraction syndrome (GRS) is linked to a cultural emphasis on fertility and procreation found in the Far East and South East Asian countries. There are two versions of Koro: one is the Malaysian/Indonesian and the other is the Chinese version (Haque, 2008). The word Koro is thought to have originated from the Malaysian word for tortoise, which was locally used as a slang term for male genitals. In Chinese, the term suo yang translates to “shrinking penis”, which represents not a physical illness as such but an extremely deficient yang or male energy. Attacks of Koro are often set off when men are in situations that would normally cause the male genitals to shrink slightly, such as emotional distress or cold temperatures. The disorder is also attributed to unhealthy or abnormal sexual practices like masturbation or having sex with prostitutes, which upsets the yin/yang balance that is found in the normal relationship of a husband and wife (Haque, 2008).

Hwa-byung (fire or anger syndrome)

This is a mixture of various neurotic and psychosomatic symptoms of traditional Korean people reacting to a stress-ridden situation, usually in an interpersonal context. Hwa-Byung was first described by an American psychiatrist in 1983, who published an article about
a South Korean woman’s depression-like symptoms that he called anger syndrome (Lin in Choi & Yeom, 2011). The term Hwa-Byung is a combination of Hwa, meaning fire (anger), and Byung, meaning disease. It is considered a culture-bound syndrome because it manifests predominantly in women of Korean heritage when they suppress anger, frustration, hate, animosity, and other negative feelings toward members of their family or significant others. The course is short and disappears soon after resolution of the stress (Kim, 1995; Cheo & Yeom, 2011). Hwa-byung presents itself initially as nervousness and later develops into depression (Lee & Jung, 2011). Min and Lee (1989) add that if these feelings are suppressed for a long time, a group of psychosomatic symptoms develop, which include depression, anxiety, panic, lumps in the upper chest, palpitations, or feelings of impending doom.

The unique features of Hwa-Byung that differentiate it from other mental illnesses, especially depression, are that patients acknowledge that they have Hwa-Byung; they have felt guilty for having it; they have been submissive or obedient; they have hidden their anger or negative feelings; they have sighed often; they have generalised anxiety; they have felt something was pushing up inside their chests; they had often felt their heart pounding; and yet they have extreme resilience and no suicidal ideation or attempts (Cheo & Yeom, 2011). Expressing one’s emotions is looked down upon by the Koreans, as Confucianism emphasises emotional and behavioural control in order to cultivate harmonious hierarchical interpersonal relationships (Lee & Jung, 2011).

Shin-byung

This is a possession syndrome which occurs in the course of a prolonged psychosomatic illness, neurosis or psychosis. The possessed person has a revelation through a
dream or hallucination; the possessor is usually the dead ancestor. With the person’s conversion into a shaman, the person then becomes cured of the ailment (Kim, 1995).

**Bebainan**

This is a mental illness which the people of Bali believe to be caused by the individual’s soul being possessed by a malignant spirit called the *bebai* (Suryani, 1995). The onset is sudden and it is not preceded by physical symptoms. Several triggers are thought to be responsible for the onset of the illness:

- *Kajeng kliwon*: a day which comes every fifteen days by the Balinese calendar. This is a fearful day because on this day evil spirits abound and people with bad intentions may easily be possessed and disturb others.
- Emotional stress
- Physical exhaustion
- The morning after a sleepless night
- Other Balinese holidays
- No reason

Suryani (1995) lists the symptoms as follows: feelings of confusion; a cold feeling beginning in the legs then spreading to the rest of the body; feeling empty; ringing in the ears; a feeling that the surrounding environment has gone dark; stomach ache; a feeling of fear when seeing certain things; and stiffness of the body. After experiencing these symptoms, the individual reports suddenly losing control of themselves. The symptoms last only fifteen minutes to one hour.
**Enloquecer (to be driven insane)**

This is a mental illness experienced by people in Uruguay which is characterised by the following symptoms: the patient babbles; acts oddly; speaks or laughs when alone; quarrels or acts aggressively; screams or cries. This illness is said to be noticeable in the patient’s eyes and the way they look. It can be roughly compared to psychosis (Bespali de Consens, 1995).

**Mal de ojo (the evil eye)**

This is a Uruguayan mental illness restricted to children. Its symptoms are: headache, sleeplessness, drowsiness, fever, fixed stare and digestive disturbances. *Mal de ojo pasado* is a severe form which usually ends in death (Bespali de Consens, 1995).

**Nangiarneq**

This is a phobic state that was known and named in West Greenland before colonisation. It is characterised by social withdrawal, permanently leaving society to live alone (being transformed into a *qivittoq*) and suicide. It was suggested that when the anxiety could not be handled with support from the group and when the anger could not be expressed openly, there were few alternatives to withdrawal (Lynge, 1995).

**Anorexia Nervosa**

This is an eating disorder that first appeared among daughters of the Western bourgeoisie in the 19th century; the typical phobia of being fat was not described until 1930 (Pfeiffer cited
in Jilek, 2001). Anorexia nervosa remained a condition predominantly affecting female teenagers in affluent families of Western Europe and North America (Jilek, 2001). The DSM-IV-TR defines anorexia nervosa as:

1. Refusal to maintain body weight at or above a minimally normal weight for age and height
2. Intense fear of gaining weight or becoming fat, even though underweight
3. Disturbance in the way in which one’s body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or denial of the seriousness of the current low body weight
4. In post-menarcheal females, amenorrhea, i.e., absence of at least three consecutive menstrual cycles.

Keel and Klump (2003) suggest that weight concerns may be a culturally bound phenomenon which is restricted to socio-cultural contexts that idealise thinness and denigrate fatness. The next section describes culture-bound syndromes that occur among South African Blacks.

The Amandiki

There are different explanatory frameworks that are used to account for the expression of human psychological distress; terms such as possession, bewitchment, hysteria, mental illness, psychopathology, psychosis, nervous breakdown and so on resonate with our efforts to come to terms with states of mind that are both universally recognisable and culturally specific (Parle, 2003). Amandiki has been described as a psychological response to the enormous social pressures experienced by African women. Parle (2003, p.108) explains
the different descriptions of the amandiki by three anthropologists: Ngubane reported that the indiki possession is closely related to an extreme form of depression or nervous breakdown which may be coupled with hysteria and suicidal tendencies. Patrick Harries explains the practice in Mozambique as the expression of women’s ‘libidinal and aggressive sentiments’ in the face of the extended absence of men on migrant labour contracts. Harries adds that the psychological pressures experienced by women were intensified as concepts of female worth, defined both subjectively and objectively, suffered a relative decline and patriarchal authority increased at a time when women carried a heavy burden within the domestic economy. These women suppressed their aggressive feelings; they were trapped within a culture that, in a contradictory manner, required both obedience and a commanding strength. Sean Hanretta suggested that indiki may be part of a process by Zulu women to claim dominance as izangoma or diviners. The amandiki often spoke in a deep voice, demanded contributions from the relatives, and would occasionally strike people without reprisals; therefore spirit possession could be both a medium of protest and a means of exercising emotional control in the homestead or with the family.

**Mafunyana**

Mafunyana is described by Niehaus et al. (2004) as a culture-bound syndrome where the person speaks in a muffled and strange voice and their behaviour is strange and unpredictable. Mkize (1998) argues that the syndrome is caused by bewitchment, sorcery or spirit possession. Asmal et al. (2011) maintain that Mafunyana is used as a socially accepted explanatory model for containing inner turmoil and (Mkize, 1998) is a response to psychosocial stressors. According to Scott and Browne (cited in Mkize, 1998), this condition affects mostly women over the age of 13 years and cuts across all religious, educational and
occupational groups. Some of the symptoms are (Cumes, 1995) weeping, tearing off clothes, aggressiveness and self-injurious behaviour. Neppe and Tucker (cited in Mkize, 1998) add that it may be difficult to differentiate Mafufunyana from schizophrenia as it is also characterised by delusions and hallucinations. Watts (cited in Cumes, 1995) argues that the syndrome reached epidemic proportions in the 1920s and 1930s and Lee (cited in Cumes, 1995) maintains that it is assumed to have been due to acculturative stresses.

African authors argue that mental health care has been in the hands of traditional and spiritual healers for many centuries; the argument is that African knowledge can offer and contribute to Western science regarding treatment of psychosis (Mosotho et al., 2011).

**African Culture and Mental Illness**

Indigenous and faith-based approaches to mental health remain largely marginalised within the health care system and yet they offer a far more complex and holistic understanding of disease and the person (Mkhize, 2012). Yen and Wilbraham (2003) argues that constructions of *Ubuntu*, which is a fundamental humanity and caring for the wellbeing of others, are often cited as evidence of an African communalism that is holistic, natural and loyal to ancestral tradition. Therefore, African culture might be theorised as hospitable to the mentally ill. These representations are counterpoised against constructions of western individualism, which appears as ‘advanced’ or modern yet is based on ‘selfish’ individualistic interests and achievements, competition and pressure to succeed.

Evidence suggests that many people in non-Western societies have evolved meaningful constructions of the self, including notions of health and illness that are different from Eurocentric representations of the human condition (Mufamadi & Sodi, 2010). Patel
(1995) claims that, in many Sub-Saharan African cultures, the soul and spirit are concerned with mental life and emotions, and some authors suggest that illnesses of the ‘spirit’ and of the ‘soul’ are probably similar to mental illness. The somatic localisation of the soul and mind is perceived to be in the head, chest and/or abdominal regions.

Patel (1995) explains the major categories of disturbed behaviour that reveal similarities with behavioural disturbances associated with acute psychoses (e.g. agitation, disrobing, sleeping less, aggressive behaviour, unpredictable behaviour, suspiciousness), major depression (e.g. not eating, becoming very lazy, crying because the heart is sore, becoming thin) and a category with more diffuse boundaries called *isifo esimhlophe*, which is an indication that the sufferer is being called to become a spirit medium or healer or headman. The symptoms begin with sensations of palpitations, throbbing, epigastric discomfort and are often accompanied by psychotic behaviour, hallucinations which inevitably involve the ancestors guiding the patient towards becoming a medium (Patel, 1998). Other categories are attributed to external causes including: failure to propitiate the ancestors with the necessary sacrifices or rituals; non-observance of taboos and consequent ancestral displeasure; bewitchment; intrusion of evil spirits sent by sorcerers; and excessive worry over matters ‘which have been kept to himself’.

Patel (1998) further discusses different behavioural manifestations that characterise mental illness in Zimbabwe: *Kupengakwechitsiko* resembles an anxiety state or hysterical disorder and is characterized by the display of a mental imbalance in the presence of people, which goes away when the person is away from them. Other categories include the eating of mud or other ‘dirty’ matter, and continuous repetitive behaviour or movements such as a drummer who cannot stop drumming. In *ebebzi*, the person suddenly starts talking nonsense or performs senseless tasks but is normal in lucid intervals; in *inzuwanda*, a person
may commit crimes such as theft, and imagines that something is continually moving over his body; in *mamhepo*, a person may behave like an animal and may become very agitated, often requiring restraint. Mental illness caused by a witch is believed to be far more serious than that caused by ancestral spirits. Some disorders can also be classified on aetiological grounds: thus, *rema* signifies a mentally handicapped child, born handicapped because of an angry spirit; *kutanda botse* is when a person wanders in a dishevelled state, wearing only rags, moving from village to village and is due to angry spirits. *Kufungisisa* is when one thinks too much and this can be related to the biomedical construct of depression and anxiety. Hearing voices is often a sign of mental disorder and is believed to be the work of ghosts. Ghosts also cause an affliction in which a person suddenly disappears every now and then; this is called *masaramusi*.

In South Africa the vast majority of the population cannot afford psychologists/psychiatrists and even if they could, there is evidence that they would still prefer healing services that are in line with their indigenous models of health/illness and explanatory models (Mkhize, 2012).

Studies with the AmaXhosa people of Southern Africa suggest that the soul is considered to be the seat of feelings and resides in the blood and heart. The mind is located in the brain and is “the initiator of action and required for health” (Cheetham & Cheetham, 1976). Unlike European concepts which emphasise the cognitive component of mental life, the AmaXhosa emphasise the behavioural and, to a lesser extent, the emotional components. The AmaXhosa of Southern Africa recognise a range of mental illness, but only a few are considered to be due to constitutional abnormalities of the brain.
A study done in Pretoria, South Africa, found that most patients perceive the causes of their mental illness as being dirty blood, bewitchment and bad luck; social stressors were perceived as contributing factors towards mental illness (Motlana, Sokudela, Moraka, Roos & Snyman, 2004). About 60% of the patients from the above study first consulted traditional healers before presenting themselves to psychiatric services.

Clinicians working in mental health care centres should critically assess their own perception of psychosis and psychotic disorders and reflexively determine how these perceptions may be projected on to the client. A study by Campbell-Hall, Petersen, Mjedu, Hosegood and Fisher (2010) which was done in KwaZulu-Natal found that there was a need to develop models of collaboration that would promote a workable relationship between the traditional and the Western healing systems for mental illness. In non-Western cultures, non-adherence to biomedical treatments may sometimes be the result of lack of consideration for the patient’s explanatory model of illness (should it differ from the biomedical) in the treatment regime (Bhangwanjee, cited in Campbell-Hall et al., 2010).

**Traditional Healers and their View of Mental Illness**

Traditional healers play a vital role in the treatment of mental illness in South Africa. Most patients with mental illness consult the traditional healers for an opinion regarding treatment of their illness. At some institutions, traditional healers form part of the multi-disciplinary team that offers services to patients with mental illness. An appreciation and understanding of the concepts of mental illnesses held by traditional healers, as well as their treatment practices, would help mental health services in developing different contexts which might shed light on the debate concerning the most appropriate way to collaborate with traditional healers (Sorsdahl, Flisher, Wilson & Stein, 2010). A study done
by Sorsdahl et al. in Mpumalanga, South Africa (2010) found the following: mental illness was a distinct category of illness and the symptoms were usually very specific, like extreme behavioural disturbances; violence; picking up garbage; talking randomly and undressing in public. The healers held that mental illness could have many causes, of which witchcraft and possession by evil spirits were the most frequent. Substance abuse was also believed to cause mental illness.

Mufamadi and Sodi (2010) interviewed traditional healers from Venda who identified ancestral dissatisfaction, witchcraft, untreated epilepsy, water in the head and heredity as causes of mental illness. According to these traditional healers, there are different categories of mental illnesses classified according to the cause: tshipengo or madness is caused by natural factors; tshifafa is caused by untreated epilepsy; tshifakhole (epileptic fits), if left unattended, force blood into the heart resulting in sores that cause mafhaqhado (delusions and hallucinations); thuri (animal-like creature) is caused by witchcraft. Symptoms range from senseless talk to odd behaviour, talking to oneself, social isolation, undressing in public, accusing other people of witchcraft, wondering aimlessly and aggressive behaviour. Abuse of alcohol, drugs and sexually transmitted diseases are also perceived to cause mental illness. Treatment regimens range from herbs and ointments to sedate those who are violent to the use of steam baths. Rituals like uphasa (libations) and malombo (ritual dances) are performed.

The above study found that symptoms that were described by traditional healers were similar to those found in other countries. It can therefore be argued that, although there might be slight differences in the interpretation of the maladaptive behaviour, there are striking similarities regarding the notions of mental illness in different parts of Africa (Mufamadi & Sodi, 2010).
The Xhosa health view is based on indigenous religion and ideology, and the treatment of any physical or mental dysfunction among the Xhosa speaking people accordingly requires the cooperation of other family members (Bogopa, 2010). Therefore, families of patients with schizophrenia may also share these beliefs about mental illness and its aetiology from the African perspective and assist their relatives in seeking help from indigenous healers (Asmal et al., 2011).

Summary

This chapter explored mental illness and culture and how different cultures conceptualise mental health and mental illness. A comprehensive examination of culture-bound syndromes across the world is presented. The thin line between what is deemed normal and abnormal is made apparent. The role of traditional healers and the African traditional churches in mental health cannot be over-emphasised.
People are always selling the idea that people with mental illness are suffering. I think madness can be an escape. If things are not so good, you maybe want to imagine something better.

Chapter 7

*If you cannot get rid of the family skeleton, you may as well make it dance.*

George Bernard Shaw, *Immaturity* (1879)

**Experiences of Schizophrenia**

Being diagnosed with a mental illness affects not only the person with the diagnosis but the whole family as well. The family has to adjust to the new roles and the changed dynamics. This chapter will examine the experiences of the family as a whole with the focus on siblings, partners and parents of individuals who have been diagnosed with schizophrenia.

**Family Experiences**

Being mentally ill is not just an individual experience; there are broader implications of being mentally unwell – it is a social experience as well. Friendships may be damaged, sometimes irreparably, as one’s close friends retreat into the background (McCann & Clark, 2004). Kbit (1998) describes schizophrenia as a family affair, as the functioning of the entire family is affected by the diagnosis of the illness in one member.

Mental illness is perceived as a catastrophic experience, as the illness gets in the way of social relationships and the side effects of medication become burdensome not only for the person with the illness but for the family members as well (McCann & Clark, 2004). Some family members describe the experience of personal loss due to their loved one’s mental state as being as severe as the loss of a loved one through death (Fleck, 1960; Gerace, Camilleri & Ayres, 1993; Maunu& Stein, 2010).

Brady and McCain (2004) highlight the changes that occur in the family which necessitate a rearrangement of the family’s developmental needs. The family system focuses
on the ill family member while ignoring the needs of the other members of the family. Brady and McCain add that there are invariably role changes in the family. Caregivers have to adopt the role of caring and need to be agents of social change as well. For example, when negative symptoms of schizophrenia are pronounced, such as poor motivation and a reluctance or inability to maintain good personal hygiene, caregivers are obliged to enforce cooperation in certain activities from the uncooperative ill family member.

Brady and McCain (2004) explain that the uncertain course of the disease, disturbing behaviour, loneliness, lack of external support from people other than family members, lack of reciprocity in relations with the patient, continual grieving for the member's lost potential, and fear of unpredictable mood changes including violent outbursts, are identified as problems by family members of chronic patients. The basis of family reaction to their relative’s schizophrenia-associated symptoms has often been rooted in how the family interpreted these symptoms.

According to Jonker and Greeff (2009), caregivers report several challenges, one of which is the loss of their freedom. The responsibility of caring prevents them from doing things that they would rather be doing instead of keeping an eye on an unpredictable ill family member. Caregivers also experience feelings of ambivalence about offering care to their ill family member; they do not want to offer care to their ill family member, but at the same time feel obliged to do so. Siblings and parents are often embarrassed by the symptoms and behaviour of the ill member and avoid bringing others to the home (Bernheim & Lewine, 1979; Brady & McCain, 2004).

Some relatives reject the idea of having a mentally ill patient in the family; they tend to deny that the illness is mental and try to get the patient not to exhibit signs of illness
Phelan, Broment and Link (1998) discuss Lefley’s study on family stigma and schizophrenia which found that family members were reluctant to disclose their ill family member’s psychiatric diagnosis because of the derogatory remarks that colleagues passed about patients with schizophrenia. Gawad further points out that one of the reasons for keeping the illness a secret is to avoid humorous comments from the neighbours and to protect the patient’s social status in school or at work.

Approximately one-third of patients sometimes have delusional ideas of various kinds, for example, that a family member is plotting against them or that poison gas is leaking into the house. The verbalisation of these ideas, as well as the behaviours associated with them, like refusing to eat, is most frustrating for family members (Bernheim & Lewine, 1979; Lukens, Thorning, & Lohrer, 2002). A study by Saunders and Byrne (2002), which examined what living with someone who is diagnosed with schizophrenia is like, found that families had feelings such as depression, apathy, bewilderment, isolation, helplessness, denial, frustration, uncertainty and chronic sorrow. Some family members have a strong desire to help their sick loved ones; however, due to lack of support and information, they struggle to manage odd behaviours or access resources, which increases their feelings of helplessness and frustration (Barnable, Gaudine, Bennett & Meadus, 2006).

Deficits in social role performance on the part of the ill family member were the greatest factor contributing to the family care burden (Brady, 2004). However, unlike family studies from Western countries, findings from Asian, African, and Middle Eastern countries suggest that some positive aspects are associated with living with a family member who has schizophrenia (Brady & McCann, 2004).
Family members are eventually able to move beyond the illness to a place where they can see a hopeful and meaningful connection with a sibling or a child with schizophrenia. Some explained their experience as a source of value clarification, describing how it changed their attitude and made their relationships with other family members stronger (Barnable et al., 2006).

**Parenting a child with schizophrenia**

In Western culture, parental care is expected for the child, but only up to a certain age. For families with children who are diagnosed with schizophrenia, successful “launching” of a young adult never happens. In a society that values hard work, individual initiative, and independence, the person with schizophrenia is often seen in an unsympathetic light. Negative symptoms such as lack of initiative, motivation, and inability to study or work effectively are often seen as laziness or a desire to remain dependent on family or society (Birchwood & Cochrane, 1990).

According to Lefley and Johnson (1990), children who are mentally ill become dependent on their parents and the parents end up being responsible for seeking help for their mentally ill child. A major concern of parents is being long-term carers for their children. On the other hand, (Mannion, 1996) argues that parents feel that their parenting role is being amplified and that brings closeness and strengthens the relationship they have with their ill child.

According to Lewin (1979), most parents struggle to accept that their child has schizophrenia, and their denial may manifest in suggestions that all their affected child needs to do is to get a job, change friends or be more disciplined. The other compounding factor is
that the illness is unpredictable and the ill person might seem normal and competent at some instances.

Knudson and Coyle (2002) maintain that some parents use downward social comparison as a coping mechanism. For example, finding someone whose condition is more severe than your child’s makes it easier to cope with your child’s condition. This assertion is based on Festinger’s social comparison theory which states that people choose those who perform slightly better than themselves to learn how to cope effectively (Knudson & Coyle, 2002). Parents in Knudson and Coyle’s study compared their children with those whose functioning was lower so as to bolster their emotional well-being in the face of an ongoing stressful situation.

**Siblings of individuals with schizophrenia**

Growing up with a sibling who has been diagnosed with schizophrenia has long-term outcomes for the non-ill sibling. Gerace et al. (1993) report that siblings of ill patients perceive the illness as pervasive, and that it affects all areas of their lives. One subject equates growing up in a family where there is a sibling with schizophrenia to being in a war zone where there are emotional bullets which one has to constantly dodge. According to Gerace et al., siblings of ill patients feel that all the energy is focused on the ill sibling and they are denied the freedom to live their own lives. Understanding what causes schizophrenia is important for siblings of schizophrenic patients and most of them search for acceptable explanations for their sibling’s bizarre behaviour (Barnable et al., 2006).

Brodoff (1988) mentions that her family had to change in order to deal with her brother’s illness. Their family is described as resembling a fragile vessel caught in an overpowering eddy. The feeling became so overwhelming for the sibling that she was forced
to distance herself from the family in order to escape being drawn into a vortex that would most probably have resulted in emotional annihilation. Kinsella, Anderson and Anderson (1996) also state that, in order to survive the turmoil at home, siblings tend to resort to constructive escape, which is a process where one emotionally or physically escapes one’s home environment to get relief from the pressure of living with a sibling or a parent with a mental illness. The activities that such siblings engage in range from art and music to organised social activities.

Gerace et al. (1993) report on siblings who feel that they have been carrying a depression about their families for ages, and with the help of psychotherapy they have been able to accept that their family is not normal. Not everything is doom and gloom, as Kinsella et al. (1996) note that there are some positive outcomes for siblings growing up with siblings diagnosed with schizophrenia. One of the participants in the study by Kinsella et al. (1996) echoes the sentiments of one of the participants in his study who indicated that having a brother with mental illness allowed him to grow as a person, and that his brother’s illness changed his view of people in general. He learned to be less judgmental and developed an openness towards people and those suffering from a mental illness. Others learned that one has the capacity and the ability to live through anything.

Stalberg, Ekerwald and Hultman (2004) describe the following ambivalent feelings that emerged from their study: the love they felt for their ill siblings is the only thing that makes it easier to care for them and deal with the diagnosis of schizophrenia. On the other hand, the sorrow they feel for their ill sibling is expressed as loss and empathy for them. Other siblings felt angry and envious, which was a feeling they felt was forbidden. The envy was from both the ill sibling and the healthy one; the ill sibling felt that their illness made it difficult for them to progress in life like their healthy sibling. The non-ill sibling, on the other
hand, felt that the ill sibling got away with anything as they were not expected to have certain responsibilities; “there are no ‘have to’ situations in his life” (p. 449), one sibling commented.

Gerace et al. (1993) mention the collaborative approach, which is a strategy that siblings, parents and mental health professionals adopt to deal with the care of the ill sibling. One sibling says: “My mother and I take turns caring. When one of us gets burnt out, the other deals with it…we talk about everything and discuss what we are going to do”. This study showed that these siblings report high levels of distress even when they are part of a collaborative team.

Finally, (Stalberg et al., 2004) discuss a few coping mechanisms that siblings use to deal with their ill sibling’s illness: firstly, cognitive and physical avoidance is used to deal with the confusion and sadness they feel towards their sibling; secondly, they use avoidance to distance themselves emotionally from the feelings of anger and frustration; thirdly, they normalise their ill sibling’s condition. This coping strategy moves between denial and acceptance of their sibling’s illness. Fourthly, the act of caregiving is beneficial in dealing with feelings of guilt and inadequacy. There are enduring feelings of loss that these siblings experience, and allowing themselves to go through the process of grieving is helpful. However, the study found that those who used grieving as a coping mechanism struggled to maintain the balance between being involved in the care of their ill sibling and living their own lives.
Spouses of individuals with schizophrenia

Jungbauer, Wittmund, Dietrich and Angermeyer (2004) maintain that relationships for spouses diagnosed with schizophrenia remain the most important long-term social contacts for these spouses. The spouses in the study by the above authors recount the first experience of the symptoms of schizophrenia, which was very frightening for them. They did not know what was happening to their partner or what was wrong due to the unexpected nature of the illness, and they were overwhelmed and overcome by feelings of helplessness.

Anonymous (1994) mentions that one of the difficulties of being married to a person diagnosed with schizophrenia is that one’s social life becomes negatively affected; there is social isolation as a result of the embarrassment that the other spouse feels due to the ill spouse’s inappropriate behaviour in public. Anonymous also mentions that the paranoia that the ill spouse has makes life very complicated; she reports that even non-complex activities take twice as long as before. For example, when her husband was making a bookcase, he had to use more nails, as he believed that he needed to reinforce it in order to prevent it from collapsing should an earthquake take place. There were also feelings of guilt for being resentful of the way the spouse’s illness had taken over their lives.

Richters, Weintrub and Neale (1987) point out that higher-functioning spouses diagnosed with schizophrenia were able to maintain adequate levels of marital satisfaction. Jungbauer et al. (2004) mention that spouses find themselves taking on roles that were supposed to be fulfilled by ill spouses. For example, one woman who was interviewed by these authors says “Well, I have to take on the male role. We renovated the flat. I did all this myself…he stood there and watched me; he was not too keen to do it and had no interest in
doing all this work” (p. 669). This was a source of frustration, as she was forced to adapt to the new role. One spouse mentioned the challenge of carrying on in the midst of the chaos and she observed that the importance of standing together during the bitter hours is an art that should be acknowledged and appreciated. These spouses declare that it is very challenging for them when they are expected to do everything and to have unlimited strength.

In a study by Kaushik and Bhatia (2013), female spouses reported a below-average quality of life in their marriages with individuals diagnosed with schizophrenia. These women identified areas which were affected in their lives as: the activities of everyday life, a change in intimacy and the shift in role distribution. There were also ambivalent feelings regarding their relationships with their partners.

According to Östman and Björkman (2013), sexuality plays an important role in everyday life. Therefore, people with schizophrenia and their spouses have the need to have an intimate relationship with each other. A survey done by the above authors concluded that patients who are diagnosed with schizophrenia worry about not being able to lead a normal life in which there is healthy sexuality. Some of the patients in this study report not having had any sexual activity for periods of up to seven years. Partners also commented that their union changed from being a sexual one to a very different kind of relationship. Östman and Björkman suggest that mental health medical personnel need to give attention to sexual needs of their patients and they should be referred for couple therapy or to other professionals who might be able to assist them and their spouses. Early intervention may assist in keeping their intimate relationship intact, which may improve their quality of life.

Jungbauer et al. (2004) indicate that there is increased potential for conflict which is usually due to disagreements about everyday issues, and this may escalate if the ill partner
has aggressive tendencies. Sexual dysfunction that occurs as a result of the side effects of psychotropic medications could also possibly be due to continuous conflicts and dysfunctional communication which is prevalent in most relationships.

A study done in Nigeria found that people are willing to get into relationships with people diagnosed with a mental illness if they attribute the illness to acts of supernatural forces; they belief that the removal or appeasement of such forces will restore the ill person to normality (Ewhrudjakpor, 2009). This study also maintains that if the illness is attributed to excessive alcohol consumption or smoking marijuana, there is less sympathy towards these individuals.

**Living with schizophrenia: experiences of patients**

Schizophrenia is the cruellest disease of the Western world. It afflicts young adults, often beginning insidiously and progressing until the ambitions, potentials and hopes of early years are discarded. In their place lie broken thoughts, inappropriate or stunned emotions and internal voices or other misperceptions that can make existence a living hell (Torrey, 1980). Johnson (2012, p. 207) echoes the frustrations of living with schizophrenia:

> It is a curse, this schizophrenia, because it has me asking questions, it has me off balance, it has me questioning the very basics of the basics every 15 minutes, over and over and over again. I can never get anywhere; never make any progress past the basic questions. It looks like I am wasting time on purpose, like I’m avoiding growing up or avoiding responsibility. The more I try to speak, the less you understand me. This is why we stop trying to communicate. It’s like quicksand. It’s an inevitable and slow death. Not being able to communicate my basic feelings, not identifying with another human being, and feeling completely alone in my experience are killing me. I sit at
home alone, and I physically hurt from just loneliness. I curl up in the foetal position and hold my head. I stare at the wall and barely breathe. That's my loneliness. My loneliness is dead silence. It is pitch black. It stretches on and on endlessly.

For many participants, schizophrenia was a devastating experience that made the future even more unpredictable than it would otherwise have been. They felt alarmed because they could see no future beyond the immediate experience of their illness. Uncertainty, for some, was paramount. No longer was there the same taken-for-granted confidence in knowing their mind. When they recovered from the acute episode of illness, the fear persisted that ill health might return (McCann & Clark, 2004).

Some patients struggle to cope with the symptoms of schizophrenia. Below is a letter by L. Percy King in (Frith & Fletcher, 1995, p. 71) describing his frustration with the hallucinations that plagued him:

Days later while in the Metropolis again, I was once more startled by these same pursuers, who had threatened me several days before. It was night-time. As before, I could catch part of their talk but, in the theatre crowds, I could see them nowhere. I heard one of them, a woman, say, 'You can't get away from us; we'll lay for you and get you after a while!' To add to the mystery, one of these pursuers repeated my thoughts aloud verbatim. I tried to elude these pursuers as before, but this time I tried to escape from them by means of subway trains, darting up and down subway exits and entrances, jumping on and off trains, until after midnight…
Estroff (1989, p.189) calls schizophrenia an “‘I am’ illness—one that may overtake and redefine the identity of the person”. Estroff adds that the perception of their illness on the part of people diagnosed with schizophrenia shifts in terms of the inner self and the social identity. These individuals at times struggle to integrate their old self and the new identity which is characterised by certain incapacities. At times they perceive themselves as being “the same”; however, on the other hand, they need a measure of public validation for their illness. Johnson (2012) questions her realness and attempts to put together a self whose nature, she realises, is a constant struggle to fathom. Brady and McCain (2004) add that one of the greatest challenges for people diagnosed with schizophrenia is a loss of identity as individuals. These individuals have to adjust to the new role of being a mentally ill person.

Johnson (2012) sees herself as someone who has an illness that happened to her and she acknowledges that it is not her fault that she got the illness. Her struggle is learning to live and dance with schizophrenia; learning to acknowledge her symptoms without allowing them to take over her life. Schulze and Angermeyer (2003) argue that some individuals with schizophrenia feel that because of their diagnosis, they are not taken seriously anymore. They feel that their needs and perspectives do not matter to their family, friends or employers.

A study done by Lee, Lee, Chiu and Kleinman (2005) in Hong Kong found that a third of participants who were interviewed experienced negative comments from their colleagues and their employers after they revealed their mental illness. The others felt that prior relationships with their colleagues or school mates deteriorated after they disclosed their mental illness.

Fox (2004) recounts the pain of losing friends when this ‘thing’, the illness, did not go away. As a parent, she had to make a decision regarding when to disclose her illness to her
children. The reason for delaying was trying to find an appropriate time, that is, when they would be old enough, to tell them about her diagnosis. The other challenge facing parents with a schizophrenia diagnosis is that they may lose their children as they are deemed unfit to parent (Fox, 2004).

**Stigma and Schizophrenia**

Michaels, Lopez, Rüschi and Corrigan (2012, p. 185) describe stigma as a “socio-cultural process by which members of a marginalised group are labelled by other people as abnormal, shameful, or otherwise undesirable”. Michaels et al. also trace the definition of stigma to the ancient Roman and Greek societies where it meant markings and tattoos burnt onto the skins of slaves and criminals. This served as a visible marker of their marginal social status or deviance.

Finzen calls the stigma associated with schizophrenia a second illness, which is the reaction of the social environment to the illness and which in turn leads to social isolation, thus adding to the illness experience (Schulze & Angermeyer, 2003). Phelan et al. (1998) argue that the social characteristics of the patient and his/her family are related to the degree of stigma that is reported by the family. One of the characteristics that seemed to be associated with concealment was the level of education of the patients or the family.

Dickerson, Sommerville, Origoni, Ringel and Parente (2002) maintain that patients from families with a higher occupational level who are reared in affluence are sensitive to the way their mental illness has the potential to deny them opportunities in life. According to the study by Phelan et al. (1998), 50% of college graduates concealed their illness compared to 30% of those with less education. Concealment also appeared to be higher when there were fewer positive symptoms, and female patients concealed their illness more than male patients.
Patients and family members report that friends and relatives slowly drift away from the ill person. One of the reasons mentioned by participants in Schulze and Angermeyer (2003) is that old friends feel that they have nothing in common with the ill person anymore and there is nothing that they could talk about. The family and the patients end up with ‘inferior contacts’, which are people they meet at the hospital or the clinics, and the only thing that is discussed is the illness. Patients have therefore decided to keep their illness a secret as it is the only way of maintaining a normal life. According to Schulze and Angermeyer (2003) contact with psychiatry is perceived as a stain on their reputation.

Stalberg et al. (2004) point out that siblings find it challenging to handle the questions about their ill sibling posed by others outside the family. They are uncertain about how open they are allowed to be regarding their ill sibling’s diagnosis. There are complex feelings which include the shame of having someone with a schizophrenia diagnosis in their family and a strong respect for the ill sibling’s integrity.

Penn and Nowlin-Drummond (2001) investigated two issues which seem to be related to stigma and schizophrenia; the issues concerned the use of politically correct labels and whether this influenced the level of stigma that individuals with schizophrenia perceived from graduate students and community members. This study found that the use of politically correct labels like ‘consumer of mental health service’ seemed to be associated with a less negative emotional reaction from the individuals diagnosed with the schizophrenia. The use of this broad term which hid the specific diagnosis of schizophrenia may de-stigmatise patients; however, on the other hand, the ambiguity of the label may lead to people filling in the blanks, which may result in the unintended consequence of increasing stigma. In terms of the graduate students and the community members, the study found that there were no differences with regard to the emotional and behavioural intentions towards mental illness.
Watson, Corrigan, Larson and Sells (2007) remark that persons with mental illness have a tendency to internalise the stigma of their illness, which results in reduced self-esteem and self-efficacy. The above authors discuss a theoretical model of self-stigma which is represented in the following diagram:

**Figure 1: Theoretical Model of Self-Stigma (Watson et al., 2007, p. 1313)**

- Stigma-awareness is perceived stigma; stereotype agreement is when one endorses the common public stereotypes, for example, that people with schizophrenia are aggressive and dangerous. Stereotype self-concurrence is when one applies the culturally internalised beliefs to oneself. For example, I am aggressive and dangerous because I have schizophrenia. This results further in reduced self-esteem and self-efficacy because of agreement with the negative beliefs. Michaels et al. (2012) maintain that not everyone who is diagnosed with
schizophrenia self-stigmatises. The person with a mental illness is faced with three options: accept the public stigma as valid, reject it or ignore it.

The perception of stigma is related to the extent to which one is willing to disclose one’s illness or the illness of one’s family member. Corrigan and Matthews (2003) mention three ways people may choose to disclose: selective disclosure, indiscriminate disclosure and broadcasting. According to Corrigan and Matthews, broadcasting seems to be the most beneficial for the stigmatised person as it creates a space where other people can be educated about mental illness; it fosters a sense of power for those disclosing. Corrigan and Matthews (2003, p. 241) list the benefits and costs of disclosing one’s illness. Firstly the benefits are:

1. Psychological well-being
   - Increased self-esteem
   - Reduced distress
2. Diminished risky behaviour
3. Facilitation of interpersonal relations
4. Enhanced relatedness to key institutions like work

The costs are:
1. Physical harm
2. Social avoidance
3. Social disapproval
The above points indicate the significance of stigma, be it real or imagined. The ideas people have about how they are perceived by others affect all facets of their lives, personal, occupational and financial.

Dickerson et al. (2002) suggest that strategies are needed to alleviate the stigma that is experienced by people diagnosed with schizophrenia. The following are the suggestions by Dickerson et al.: self-help groups and advocacy organisations; training in the appraisal of social situations and specific techniques of self-disclosure, and challenging the shame about mental illness. These strategies may improve self-esteem and enable people diagnosed with schizophrenia to be resilient in response the perceived stigma.

Michaels et al. (2012) further recommend the following strategies to change public stigma: educate the public about the myths regarding mental illness; secondly, increase interpersonal contact with people diagnosed with mental illness, including one-to-one contact with patients. This will increase the potential for friendships between people with mental illness and members of the public, which might debunk the stereotypes that prevail regarding mental illness. Thirdly, they suggest social activism to highlight injustices done to mentally ill people.

**Summary**

Schizophrenia is a family illness; it affects everyone who is connected to those diagnosed with the illness. Families have to adjust their functioning as roles are changed due to the illness. Parents are taken care of; siblings are forced to take care of their ill brother or sister and wives have to take on the roles of husbands. Schizophrenia undermines one’s sense of being with the resultant stigma that is prevalent among patients and families of individuals diagnosed with the illness. Besides the challenges, there is hope and resilience as families
develop coping mechanisms and discover their strengths. The next chapter examines the theoretical framework that informed this study.
I attempt to guide, not to instruct, but merely to show and to
describe what I see. All I claim is the right to speak according to
my best lights, primarily to myself and correspondingly to
others—as one who has lived through a philosophical existence in
all its seriousness.

Edmund Husserl, Husserliana (1936)
Chapter 8

Phenomenology

This study focuses on meanings that individuals with schizophrenia attach to their illness and also seeks to explore the experiences these individuals have as people diagnosed with schizophrenia. Phenomenology seemed to be the most appropriate theoretical framework for informing this study. Phenomenology (Landridge, 2008, p. 4) is understood as “a discipline that focuses on people’s perceptions of the world in which they live and what it means to them”.

Phenomenological philosophers have been “extraordinarily diverse in their interests and their interpretation of the central issues of phenomenology” (Moran, 2000). Moran further states that the term phenomenology has been used in philosophy since the 18th century by scholars such as Lambert, Kant, Fichte and Hegel. The first documented use of the word phenomenology is in the work of Heinrich Lambert in 1764 (Spiegelberg, 1960; Moran 2000). According to Moran, Lambert, in Novus Organon (Moran, 2000) used the word to signify a science of appearance, which allows us to proceed from appearance to truth; Lambert perceived phenomenology as the theory of illusion (Schein) and its varieties (Spiegelberg, 1960). According to Moran, Kant got his inspiration from Lambert and used the term phenomenology in many of his early letters. Spiegelberg (1960) points out that Kant thought that phenomenology was not merely a study of illusion but what he called the critique of pure reason. In 1772 Kant spoke of phenomenology in general, which developed into the Transcendental Aesthetic section of the Critique of Pure Reason. Kant perceived phenomenology as that branch of science that sought to deal with things in their manner of appearing to us (Moran, 2000).
Spiegelberg (1960) argues that it was Hegel who elevated phenomenology to the level of full philosophical discipline. In 1807, Hegel used the term phenomenology in the title of his work, *Phänomenologie des Geistes* (Phenomenology of Spirit). However, Moran (2000) points out that Hegel’s work remained in obscurity during the 19th century and had little influence until the 1920s and 1930s, when writers like Wahl, Kojève, Marleau-Ponty and others noticed his work and perceived him as the originator of the phenomenological method. Forerunners of phenomenology are found in the works of Kant, Hegel and Mach; however, Moran (2000) argues that phenomenology as a new philosophy was formally introduced by Husserl in his ground-breaking work, *Logical Investigations* (*Logische Untersuchungen*) in 1900-1901. It was in this volume that he discusses the need for a wide-ranging theory of knowledge, the phenomenology of the experiences of thinking and knowing. Moran (2000, p.1) further explains Husserl’s view about phenomenology in the second edition which was published in 1913:

This phenomenology, unlike the more inclusive pure phenomenology of experiences in general, has, as its exclusive concern, experiences intuitively seizable and analysable in the pure generality of their essence, not experiences empirically perceived and treated as real facts… This phenomenology must bring to pure expression, must describe in terms of their essential concepts and the governing formulae of essence…

In the next section the definition of phenomenology is examined, followed by the historical overview. The historical overview will be discussed in three sections: the preparatory phase of Brentano and Stumpf; the German phase of Husserl and Heidegger and
the French phase of Sartre and Derrida. There are many philosophers who contributed to the development of phenomenology; however the scope of this thesis does not allow a discussion of all of them. The historical overview will be followed by a discussion of Being and the African worldview; lastly, phenomenology and mental illness will be discussed.

I chose Heideggerian phenomenology for this study as I believe that, as a researcher, I cannot suspend or bracket my perception of mental illness from a Black person’s view. As a child, there was a member of my family who presented with what would be described as psychotic symptoms from a Western medical model; however, the elders in the family explained the phenomenon differently from the Western medical model explanation of mental illness. They were of the opinion that the family member was communicating with the ancestors and his odd and violent behaviour was also ascribed to ancestral involvement. I will always have these pre-understandings when interacting with someone who is psychotic, regardless of the fact that I have been trained from a medical point of view and have studied the DSM. We always bring our history with us when interacting with the present, which in turn has an influence on how we negotiate the journey towards the future.

**Definition of Phenomenology**

There are different definitions of phenomenology offered by different scholars; however, the main focus is that phenomenology has the potential to: (a) penetrate deeply into the human experience; (b) trace the essence of a phenomenon and clarify it in its original form as experienced by individuals (Kaffle, 2011). Moran (2000) points out that phenomenology is characterised by a number of themes but has never developed into a set of philosophies or been cemented into a system; phenomenology claims to be a radical way of doing philosophy, a practice rather than a system. Phenomenology is a radical anti-traditional
approach of philosophising, which explains the attempt to get to the truth, to describe
phenomena in the broadest sense of whatever appears in the manner in which it appears.

According to Moran (2000), phenomenology seeks to avoid all misconstructions and
impositions placed on experience in advance, whether these are drawn from religious or
cultural traditions or from everyday common sense; explanations are not to be imposed
before the phenomenon is understood from within. Spiegelberg (1975) adds that the name
phenomenology in the 20th century is used for a philosophical movement whose primary
objective is direct investigation of phenomena as consciously experienced, without theories
about their causal explanation and as free as possible from unexplained preconceptions and
presuppositions.

Kaffle (2011, p. 183) mentions Grbich’s definition of phenomenology as “an
approach to understand the hidden meanings and the essences of an experience.” Berrios
(Kaffle, 2011) describes phenomenology as a set of philosophical rules which loosely share
the following: an assumption regarding what the world is like and what can be known about
it; strategies that describe the management of mental entities that relate to such a world.
These two, according to Berios, capture the experiential essences which are part of the higher
forms of knowledge.

Sokolowski (2000, p. 185) defines phenomenology as “the science that studies the
truth. It stands back from our rational involvement with things and marvels at the fact that
there is disclosure that things do appear, that the world can be understood, and that we in our
life of thinking serve as datives for the manifestation of things”.

Kaffle (2011) maintains that all these different definitions focus on one thing, which
is that phenomenology has the ability to follow the essence of the phenomenon and reveal it
in its original form as it is experienced by individuals. Finlay (2008) adds that all variants of phenomenology share a similar focus, which is the description of lived experience and the recognition of our embodied and inter-subjective \(^3\)life-world.

**Historical Overview**

The development of phenomenology took place in four phases, which includes the preparatory phase dominated by the German philosophers. The German phase included, amongst others, the works of Edmund Husserl and Martin Heidegger; the French phase included the works of Sartre, Paul Ricoeur and Derrida.

**The Preparatory Phase**

**Franz Clemens Von Brentano (1838-1917)**

Even though he was perceived as the forerunner of phenomenology (Spiegelberg (1960), Brentano never saw himself as a phenomenologist; however, the term phenomenology does appear in his unpublished work. Brentano was born in Marienberg-am-Rhein in Germany on the 16\(^{th}\) January 1838; into a wealthy, well-connected, Catholic, but politically liberal aristocratic family which had originally come from Italy (Moran, 2000). Brentano studied philosophy at the University of Munich and theology at the University of Würzburg; he then went to Berlin to study under the logician and Aristotle scholar, Friedrich August Tredelenburg (1802-1872) where he attended his lectures on psychology. Brentano then moved to Münster for two semesters with one of the earliest advocates of Thomism (philosophy of Thomas Aquinas). His initial doctoral thesis was on Suarez but when his

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\(^3\) Lebenswelt- life-world comprises the world of objects around us as we perceive them and our experiences of our self (Finlay, 2008).
mentor died, he changed the title to *On the Several Senses of Being in Aristotle*. This work was published in 1862 and was dedicated to Tredelenburg. *On the Several Senses of Being in Aristotle* later became Martin Heidegger’s first introduction to philosophy and inspired Heidegger to learn more about Being.

According to Spiegelberg (1960), Brentano, who studied theology, had to negotiate the contradictions between the church and philosophy. He tried to remove the contradiction between the church’s supernatural revelation and philosophy’s reason. Brentano later resigned from the priesthood and worked at the University of Vienna.

Brentano was close to Husserl and they had a friendly relationship, however, he had little respect for Husserl’s work. Brentano’s passion was to bring a universal revolution of philosophy (Spiegelberg, 1960). He believed that he needed to bring forth proof of the divine source of all being. Moran (2000) argues that Brentano, like to his inspiration, Aristotle, sought an approach that was more problem-oriented than historical.

Moran (2000) insists that Husserlian phenomenology is an inevitable product of Brentano’s efforts. Brentano’s first concern in psychology was to find a characteristic that separated psychological from non-psychological phenomena. Brentano developed the doctrine of intentionality as the decisive constituent of phenomena and believed that philosophy was a rigorous science (Siegelberg, 1960). According to Moran (2000) Brentano reformulated Aristotle’s conception of intentionality as “the peculiar kind of self-evidence of mental states that could yield apodictic truths” (Moran, 2000, p. 23). Apodictic is defined by Merriam-Webster (2013) as “expressing or of the nature of necessary truth or absolute certainty.” Brentano understood the mind’s awareness of an object or content in terms of the traditional Scholastic doctrine of intentionality. In his lecture, *The Origin of our Knowledge*
of Right and Wrong in 1889, Brentano argued that the common feature of everything psychological, which is referred to as consciousness, consists of the relation that we have to an object (Moran, 2000). This reaction is called intentional; a relation to something which may not be actual, but which is presented as an object. Brentano added that it was possible to be intentionally related to all kinds of objects, imagined, possible and so on. In his earlier interpretation of intentionality, Brentano understood the intentional object to be an inherent relationship between the mind and its contents; intentional objects are therefore seen as purely essential and non-real (Moran, 2000).

Brentano later moved to a position which is known as reism. According to Kotarabinski (Moran, 2000, p. 50), reism means that “nothing is ever made an object of thinking but a real thing”. Moran further explains the object of thinking as what it is that the thought is about; this is irrespective of the fact that there may or may not be anything outside the mind corresponding to the thought.

**Carl Stumpf (1848-1936)**

Carl Stumpf rarely features in historical accounts of phenomenology and he never turned into a fully-fledged phenomenologist; however, no other philosopher or psychologist of the same calibre has been as important as Stumpf in spreading phenomenology in the broader sense and putting it to scientific use (Spiegelberg, 1960). Stumpf used the term phenomenology to describe the field of studies which for him had an important place in the pattern of scientific research. Stumpf, a Catholic law student, was impressed by the idea of a philosophical renaissance after the dark age of philosophical speculation. Spiegelberg points out that Stumpf had no ambition to create a final philosophical system but considered himself
to be an empiricist. According to Fissete (2009), Stumpf, in his posthumous book *Erkenntnislehre* (1939), challenges Husserl’s transcendental phenomenology.

According to Spiegelberg (1960), Stumpf spoke freely of a priori knowledge, which did not mean knowledge without experience. However, Stumpf argued that this knowledge emerged from analysis of empirical material, not concepts. Stumpf tried to discover structural connections between its elements and maintained that, in order to find those connections, we have to carry out experiments in imagination. The following are general characteristics of Stumpf’s phenomenology (Spiegelberg, 1960):

1. The subject matter of phenomenology consists of primary and secondary phenomena. Primary phenomena are those contents of our immediate experience which are given to our senses. The secondary phenomena are those images as they occur in memory. Phenomena do not include those contents which are not given but are formed by the mind.

2. Phenomenology constitutes a neutral science and pre-science. Stumpf does not deny that phenomenology is a science, but he considers it to be an essential foundation of the sciences, both natural sciences and the humanities. Stumpf argues that the task of phenomenology is to analyse and describe the immediately given contents of our acts or functions.

3. Phenomenology is the first of the neutral pre-sciences. According to Stumpf, no constructs can be built without the material supplied by the phenomena. For example, our ideas are shaped by our attention and its effects.
4. Experience of felt sensations. Stumpf is of the opinion that elemental feelings like physical pains, pleasures and feelings of bodily wellbeing are described in the same way as sensations of colour and sound, which are recognised as sensations.

In summary, Stumpf’s philosophy sought to identify and explain a field of phenomena that had not been explored by Brentano. He was of the opinion that phenomenology should form the background to all sciences and that it is possible to study phenomenology with the rigour of scientific and experimental techniques. Lastly, Stumpf argued that phenomenology should not be studied as an independent discipline; instead, it should form the first layer in the study of every established science (Spiegelberg, 1960).

The German Phase

Edmund Husserl (1859-1938)

*I attempt to guide, and not to instruct, but merely to show and to describe what I see. All I claim is the right to speak according to my best light—primarily to myself and correspondingly to others—as one who has lived through a philosophical existence in all its seriousness.*


Husserl was seen as the central figure in the development of phenomenology; however, it would not be correct to say that all of Husserl’s philosophy was phenomenology (Spiegelberg, 1960). Husserl was born in Prossniz, Moravia on the 8th April 1859. He was born to Jewish parents; his father was a draper who raised the family in an irreligious
atmosphere, and it is alleged that the father tried to hide his Jewishness (Moran, 2000). Moran points out that Husserl wrote clearly and incisively, however, his published work tended to be abstract, technical and stylistically dense, and his work lacked concrete examples. Tillman (1972) indicates that one of the greatest difficulties in understanding Husserl’s transcendental phenomenological method is the language that is used to describe it; he often makes it appear highly esoteric and unrelated to anything in practice. Husserl studied mathematics, physics, and philosophy at Leipzig and he was interested in astronomy and optics. After two years, in 1878, he went to Berlin for further studies in mathematics. He completed that work in Vienna between 1881 and 83, and received his doctorate for a dissertation on the theory of the calculus of variations at age 24. Husserl briefly held an academic post in Berlin, then returned again to Vienna in 1884 and was able to attend Franz Brentano’s lectures in philosophy (Moran, 2000). He attended Stumpf’s lectures on psychology for fourteen years and later dedicated his Logical Investigations to him.

Husserl’s central insight was that consciousness is the condition of all experience, and it constituted the world in such a way that the role of consciousness is obscured and not easy to separate and describe (Moran, 2000). Moran maintains that Husserl sought to explain how to overcome the prejudices which stood in the way of the recognition of pure consciousness.

**Husserl’s Contribution to Phenomenology**

Husserl’s Logical Investigations, which is one of the most influential works of philosophy of the 20th century, contains a sustained attack on the empiricist and psychological conception of logic (Moran, 2000; Cerbone, 2006). Moran adds that the Logical Investigations is a huge unmanageable book in two volumes and is at times difficult to understand, as Husserl’s writing style in this work is not coherent. Husserl seems to have
been aware of these defects in his writing, and he spoke of its internal unevenness and fragmentary nature. Cerbone (2006) indicates that Husserl, in Logical Investigations, conceived of phenomenology as a kind of pure, non-empirical discipline which lays bare the sources from flow which the basic concepts and ideal laws of pure logic, and back to which they must be traced. Cerbone (2006) adds that it was during this time that Husserl began to think of phenomenology in transcendental terms and emphasised to a large degree the idea of phenomenology as a pure discipline. Like Brentano, Husserl had a sense of mission which he expressed in terms of the new existential philosophy, and his philosophy was not that different from that of his revered teacher (Spiegelberg, 1960). Husserl’s scientific rigour was essentially the rigour of the deductive natural sciences, an ideal that Brentano took from Auguste Comte and John Stuart Mill. In his passion for the ultimate scientific rigour and philosophical radicalism, Husserl sought to develop a phenomenology free from presuppositions (Spiegelberg, 1960). There are several concepts which describe Husserl’s phenomenology; these are discussed below.

**Intentionality**

The philosophical tradition, which was started by the Scholastics and later revived by Brentano and Husserl, claims that intentionality is the property of human consciousness of being and is directed toward or being about something (Duranti, 2000). This notion of intentionality should be differentiated from the common-sense notion associated with the doing of something on purpose, for example, “I have no intention of hurting anybody.” The thesis of intentionality maintains that every act of consciousness is directed toward an object but that this object need not exist (Moran, 2000). The investigation of the intentionality of consciousness is not only a climax in the Logical Investigation, it contains what Husserl always considered the central insight in his phenomenological analysis of insight.
Brentano, who was Husserl’s mentor, argues that the common feature of everything psychological, which is often referred to as ‘consciousness’, is the relation that we have to an object. This act is called intentional; a relation to something which may not be actual but which is presented as an object (Moran, 2000). Husserl (Spiegelberg, 1960) credits Brentano for bringing this phenomenon to his attention, but he changed it in such a way that Brentano’s initial portrayal of the concept had no resemblance to his new version. Husserl argues that Brentano’s situation of intentionality, which seeks to differentiate between the mental and the physical phenomenon, is profoundly flawed and misleading as to the true nature of intentionality (Moran, 2000).

Through Husserl, intentionality acquired the meaning of directness toward an object, rather than that of the object’s immanence in consciousness (Moran, 2000). Therefore, the acts thus directed are called intentions. Tillman (1972) describes the distinction Husserl makes between phenomenological reflection and ordinary reflection focusing on intentional acts: Husserl argues that, whilst one is engaged in searching, what one sees is the world as one structures it without being aware of structuring the world. One does not see that the world is invested with one’s intent, nor does one see that these figments of one’s intent had their source in oneself. Tillman adds that when all consciousness is made the object of phenomenological inquiry, then every meaning-giving act and meant object comes within one’s purview, “including the ‘I’ to whom meaning is present and who is the source of meaning” (p. 159).

Husserl argues that, when the intentional structure of an act is analysed, it is of no consequence at all to the phenomenological nature of the experience whether or not the object exists, is fictitious or is completely absurd. What matters is the content of what is given in a presentation, regardless of whether the presentation comes in perception or in fantasy. The
content of consciousness is given as it is, regardless of its causal origin, be it from contact with an outside object or with an inner act of the mind (Spiegelberg, 1960).

Dreyfus (1972) further explains Husserl’s analysis of the meaning-conferring or what he calls the “signifying” acts which have a meaning or sense, whether they have a filling or not. Husserl argues that by virtue of this sense, the subject intends or means an object, regardless of whether the object meant is actually present in our experience. Even if the object does not exist, even if it is unimaginable like a square circle, each time I conceive of the object or understand a reference to it, I do so by virtue of the meaning correlated with my act. The meaning is not dependent on the existence of anything beyond the act itself; the meaning is therefore called the content of the act. Husserl goes on to stress the “difference between the contents of experience and the properties of the mind-transcendent object, for example, when I see an object I only see it from one side, in a certain kind of light, from a certain angle and so on” (Moran, 2000, p.116).

Moran (2000) indicates that an important element of Husserl’s intentional modalities is his distinction between the various ways in which the object is presented or given. Husserl sees mental processes as object-directed acts; when directed at a material object, the act is always only a partial view of the object. However, it has the sense of grasping the object as it is. Cerbone (2006) further clarifies the distinction that Husserl makes between mental and physical objects: when we look at an object, for example a rock, we can see it from more than one side. I can hold the rock in front of me and turn it around so that I see it entirely but from different sides; these different sides present different viewing pleasure. I cannot see the rock in its entirety at any given time; therefore, I may never know what a complete perceptual experience of the rock will entail. On the other hand, when it comes to consciousness, these essential features of physical objects can be seen to be lacking. For example, I cannot shift
the experience I had with the rock to my perception of it. Although the rock presents itself from one side or another, this is not the case with my perception of it. My experience is just the presentation of the rock and nothing more; I cannot turn around my experience in the same way that I did with the rock, see it from different sides. My experience does not have different sides as the rock does. Unlike the rock, which has endless possible presentations or appearances, the appearance is exhausted by its appearing. There is nothing more to the appearance than its seeming the way it is; for example, while the rock might look blurry, but really have sharp or smooth edges, this is not the same with my blurry experience of the rock (when I put on my glasses, I have a new experience, rather than a new perspective of the old one).

The Reductions

Pure or transcendental phenomenology will be established not as a science of essential facts but as a science of being (as “Eidetic” science); a science which aims exclusively at establishing ‘knowledge of essences’ and absolutely no facts. Edmund Husserl, Ideas 1

Føllesdal (2006) maintains the reductions were introduced by Husserl as part of his transcendental turn. The term reductions was used by Husserl before 1891 towards the end of his first book, Philosophy of Arithmetic. In his next major works, The Logical Investigations (1900/1); The Ideas 1 (1913); the Cartesian Meditations (1929) and his last work, The Crisis (1954), the word reduction became the central topic (Føllesdal, 2006).

Moran (2000) maintains that in order to escape from the natural attitude which makes doing philosophy difficult, it is necessary to use a set of procedures which he labels as the reduction. Reduction comes from the Latin reducere, which means to lead back. Moran (2000) argues that the notion of reduction allowed Husserl, firstly, to detach from all forms of
conventional opinion, including our common-sense psychology. The reductions allowed us to detach from our accrued scientific, philosophical and metaphysical theorising regarding the nature of the intentional. Husserl argues that the reduction allows us to put aside beliefs about beliefs. Secondly, it allowed him to return to and isolate the central structures of subjectivity. Woodruff and McIntyre (1982) discuss three types of reductions:

**Psychological or phenomenological reduction**

This type of reduction seeks to focus our attention on consciousness and its experiences rather than on the various external objects which occupy consciousness. According to Føllesdal (2006), the phenomenological reduction leads us from the natural attitude where we are directed toward individual, physical objects, to an eidetic transcendental attitude. Woodruff and McIntyre (1982) describe the natural attitude as the everyday, pre-philosophical attitude that occurs in our conscious life. This natural attitude is our taking for granted that the natural world exists and that the objects we intend are real entities within that world and that our experiences are part of that world. In the Cartesian Meditation, Husserl discusses the psychological reduction as the reflection that takes place within the natural attitude.

According to Spiegelberg (1960), Husserl, who was a mathematician, associated the original and basic meaning of reduction with the mathematical operation of bracketing. The underlying assumption of this idea is that we are to detach the phenomena of our everyday experience from the context of our naïve or natural living while preserving their content as fully and purely as possible. This, according to Husserl, involves the suspension of judgment as to the existence or non-existence of this content without denying or doubting its existence.
In the first edition of the *Logical Investigations*, Husserl presented phenomenology as a pure, presuppositionless science of consciousness; the overarching assertion was that phenomenology cannot use the results of any other science in its investigations (Moran, 2000). For Husserl, pure science is that science which is stripped of all empirical content; pure science provides essential knowledge of the structures that are used for knowing; pure science perceives and imagines regardless of the existence of what is out there. Husserl states in the *Cartesian Meditations* that everything one needs one must discover within oneself, which includes the very meaning of one’s philosophical terms. This means that the phenomenologist has to begin “in absolute poverty, with an absolute lack of knowledge” (Moran, 2000, p. 126). Moran (2000) indicates that this stance that Husserl took was criticised by a lot of philosophers, including Hegel; they argued that it is impossible for a science to be presuppositionless. Moran provides Husserl’s counter-argument that his presuppositionless position in scientific enquiry does not mean that we cannot begin our enquiry from our ordinary experience or use our own language and thought processes, but that we should not assume any philosophical or scientific theory and we should avoid deductive reasoning.

According to Moran (2000), nothing should be taken for granted or assumed external to the lived experiences themselves as they are lived. Husserl in *The Idea of Phenomenology* lectures in 1907 emphasises that phenomenology must return to what is directly given in exactly the manner in which it is given. Therefore, the appeal for a presuppositionless knowledge is tied to what is essentially given in our intuitions unless we are aware of our intuitions. Husserl further adds that phenomenology focuses entirely on what is given in intuition and is not meant to depend on logical inferences or mediate knowledge of any kind.
(Moran, 2000). Therefore, Husserl argues, for experience to be explored in a pure manner, assumptions should not be allowed to contaminate it.

According to Woodruff and McIntyre (1982), the suspension of these presuppositions is what Husserl refers to as ‘epochê’ or ‘bracketing’ the thesis of the natural attitude. Woodruff and McIntyre (1982) maintain that to bracket the thesis is to refuse to make the assumption that there is a real natural world to which our intentions relate. The purpose of bracketing or epochê is to turn our attention away from the objects of the natural world so that our inquiry may focus on the fundamental evidences on which our naturalistic beliefs about these objects are based; this is what Husserl refers to as reflection. Tillman (1972) claims that the technique of phenomenological reduction provides an essential tool for revealing biases, not only of ordinary task-related activities but the beliefs that are rarely acknowledged and theories that are buried in all practical and theoretical disciplines.

Husserl’s project was initially concerned with clarifying epistemological concepts and grew later into an a priori transcendental science of pure consciousness. He argued that without this leading back, which can also occur through reduction, genuine phenomenological insight would be impossible (Moran, 2000).

The Transcendental Reduction

Woodruff and McIntyre (1982) describe the transcendental reduction as a type of reduction that seeks to eliminate from the study of consciousness all empirical or naturalistic considerations. The transcendental reduction brings forth the pure version of phenomenology that is suitable for Husserl’s philosophy.
Sokolowski (2000, p. 58) indicates that the word transcendental means going beyond; this is based on its Latin root, “transcendere, to climb over or go beyond, from trans and scando”. Sokolowski (2000) claims that consciousness is transcendental, even in the natural attitude, as it goes beyond itself and those things that are given to it. The transcendental is, therefore, the turn toward the ego as the agent of truth. Philosophy begins when we develop a viewpoint towards a natural attitude and all that is related to it; we stand back and try to gain evidence towards the truth; we consider the natural attitude. This move of standing back enables us to have an opinion outside the natural attitude; this moving back is what is referred to as the transcendental reduction.

**Eidetic reduction**

The technique of eidetic reduction is used to establish the essential nature of a concrete act and its components through analysing its various possibilities and impossibilities. This is done by freely but systematically considering the various shapes of an object in the imaginative sphere, which makes the elements necessary for understanding the essential nature of the object become evident; therefore, revealing a field of pure phenomenon (Lydall, 2004). Husserl explains this more in The Idea of Phenomenology (Moran, 2000, p. 134): “For example, I have a particular intuition of redness, I stick strictly to the pure immanence, I cut out any other significance or redness, or any way in which it may be viewed as transcendent (i.e., the redness of a piece of paper on my table). Now I start to grasp in pure seeing, the meaning of redness in general”. The colour red becomes the universal seen, not the particular this red or that red, but redness in general. This is what Husserl describes as the essence of redness. Moran argues that the eidetic seeing requires a
move from the here-and-now individual experience, the occurring *Erlebnis* (experience), to the contemplation of its essence.

Moran (2000) suggests that Husserl perceives phenomenology as an eidetic science; he argues that training ourselves to look on essences is difficult and we need to be constantly cautious that we do not allow naturalistic assumptions about the world to slip back in and contaminate and colour our view of phenomena. Husserl points out that the important step in eidetic reduction is to realise that what is given in seeing a red paper as red is not an individual fact but an understanding of the essence itself. Therefore, the basic statement of Husserl’s claim about seeing these essences is that I can grasp the essence of the colour red not just from the perception of the red paper, but from an imagined red paper or a remembered one. The science of essences has nothing to do with actual existence, but moves into the sphere of possibilities. According to Husserl, eidetic sciences have nothing factual about them; however, factual science depends on eidetic insights. Husserl stresses the importance of moving from the mere factual level to the level of essential truths, of essences (Moran, 2000).

**The life-world**

Moran (2000) points out Husserl’s interest in the life-world, which dates from the period of writing *Ideas I* around 1913. The unpublished *Ideas II* has strong references to the environment or surrounding world (*Umwelt*) as well as the life of culture and spirit (*Geist*). However, the notion did not become a major theme in Husserl’s work until the 1920s and 1930s. According to Moran (2000), the life-world is the world of pre-theoretical experience; it is also that which allows us to interact with nature and allows us to develop our own cultural forms. Moran further adds that Husserl perceived the life-world as the universal
framework of human endeavour. Husserl argues that as conscious beings we always inhabit the life-world; it is pre-given to us. Husserl (Moran, 2000) insists that the life-world allows objectivity and “thinghood to emerge in the different ways in which they do emerge in different cultures” (p.182). Different societies have different viewpoints and different ways of understanding nature; however, Husserl believes that a basic interrogation of these cultural differences reveals the invariant structure of the life-world (Moran, 2000).

Luft (2004) adds that the world is a face of interests that shows itself one way or another. Husserl views the life-world as the totality of life in its infinite facets. The world is not an absolute being, but is relative to the experiencing subject. The life-world is the field in which life in general carries itself out in its everydayness. Whether Husserl calls this phenomenon life-world or “natural world-life,” he alternately emphasizes either the noematic (the world) or thenoetic (the subjective, living) aspect.

**Heidegger (1889-1976)**

Martin Heidegger is undoubtedly one of the greatest philosophers of the 20th century. He was born of lower middle-class Catholic parents in a small town of Messkirch in the Baden-Württemberg region of Germany on the 26th September 1889 (Moran, 2000). Heidegger attended the Jesuit school in September 1909 in Feldkirch Austria, but was forced to terminate his studies due to ill health. He was transferred to the diocesan seminary in Freiberg and studied there for four semesters. He first studied theology and then philosophy together with science and history (Mueller-Vollmer, 1986). He graduated with a doctoral degree in 1913, got his second doctorate three years later under the directorship of a Neo-Kantian philosopher, Heinrich Rickert, and began teaching that same year. His ground-breaking work, *Being and Time (Sein und Zeit)*, though dense and difficult, is a philosophical
masterpiece on the same level as Emmanuel Kant’s *Critique of Pure Reason*, Hegel’s *Phenomenology of Spirit* and Husserl’s *Logical Investigations* (Mueller-Vollmer, 1986). In 1907, he was presented with a copy of Brentano’s 1862 study, *On the several senses of Being in Aristotle*; this book became Heidegger’s Bible. Brentano’s work outlined the different senses of ‘being’ in Aristotle (Moran, 2000). In 1919 Heidegger was accepted into the post of *Privatdozent* at Freiburg University at the recommendation of Husserl. Heidegger became Husserl’s assistant, and it was in Freiburg that he first encountered the latter’s work; including the famous text *Logical Investigations* which left a profound impression on Heidegger yet instilled an inquisitive sense of incorrectness (Moran, 2000). According to Moran (2000), it was around this same period that Heidegger became familiar with hermeneutics through the writings of Schleiermacher.

Heidegger’s personality was not the most appealing and Moran (2000) describes Klemens Von Kemperer’s summation of Heidegger’s unattractiveness as a person: however self-possessed and dedicated to his work, Heidegger was humourless, unfaithful to his friends and, like too many of the Germans during the National Socialist era, he lacked moral courage. His external appearance added to his dreadful personality, from his beady eyes and moustache to his dress code which was a cross between a Black Forest (the area he born in) peasant’s jacket and a military blouse complete with swastika; many people were put off by his meta-language as it was difficult to understand at times.

Spiegelberg (1960) states that the most challenging hurdle in an attempt to understand Heidegger’s writings was the difficult words he used in his work. No reader without an outstanding command of German could expect to understand the sense and the full meanings of Heidegger’s language. Spiegelberg adds that even native Germans found it difficult to understand Heidegger’s way of writing; he invented new words based on outdated root
meanings and he also used existing words for new and unheard-of purposes without first clarifying what the new meanings of the words were. This lack of clarity and clumsiness in his writing had the effect of “deepening the enigma of his impact” (Spiegelberg, 1960, p. 273).

**Heidegger and Phenomenology**

In describing Heidegger’s definition of phenomenology, Palmer (1969) discusses how Heidegger went back to the Greek roots of the word: *phainomenon* or *phainesthai* and *logos*. *Phanaimenon*, according to Heidegger, means “that which shows itself, the manifested or revealed (*dasOffenbare*)”. The *pha* is similar to the Greek *phōs*, meaning light or brightness, that in which something become manifest or can become visible. Palmer adds that phenomena are, therefore, the collection of what is open to the light of day or can be brought to light. The —*ology* suffix in the word *phenomenology* also has its roots in the Greek word *logos*. According to Heidegger, *logos* is that which is conveyed in speaking, which then means to let something appear (Palmer, 1969). Therefore, phenomenology, which is the combination of *phainesthai* and *logos*, means letting things become manifest as what they are, without forcing our own categories on them. It means a reversal of direction from that which one is used to; it is not us pointing out to things, rather, things show themselves to us.

Palmer (1969) points out that it is significant to note that the phenomenology that Heidegger developed in *Being and Time* is sometimes called hermeneutic phenomenology. Kurian (1994) further examines Heidegger’s description of what a phenomenon is: sometimes a phenomenon may show itself as something which it is not; this type of revealing itself is compared to semblance or seeming. Semblance has an indirect reference to the phenomenon; therefore, semblance and phenomenon are structurally connected. Heidegger
(Kurian, 1994) describes appearance as an announcing itself in or through something that shows it. Appearance announces something that does not show itself. Therefore, appearance is different from semblance and phenomenon in that it is a not-showing itself, which makes possible the appearing. For example, when one talks about symptoms of schizophrenia, one has in mind visual or auditory hallucinations. These symptoms show themselves in someone who is said to have schizophrenia. Therefore in showing itself through hallucinations, these symptoms indicate something called schizophrenia, which does not show itself. Thus, appearance is always appearance of something; it is given in a referential context.

Heidegger credits his knowledge of phenomenology to his mentor Husserl during his apprenticeship in Freiberg; Husserl made possible Heidegger’s further progress by familiarising him with the diverse areas of phenomenological research through intense personal guidance (Spiegelberg, 1960). In the phenomenology of Husserl, Heidegger found the conceptual tools which were not available to Dilthey and Nietzsche; these are the tools that allowed the being of human existence to be revealed (Palmer, 1969). However, he made it clear that what he wrote about phenomenology in Being and Time is not identical to what Husserl meant by phenomenology (Spiegelberg, 1960). For Heidegger, phenomenology is an attempt to make manifest the matters as they manifest themselves (Moran, 2000).

According to Heidegger, phenomenology is neither a standpoint nor a school of thought; for him, phenomenology means a concept of method and does not characterise the qualitative content of the objects of philosophical study, but the mode of approaching them. It is a methodological concept that deals with the ‘how’ of ‘what’ is to be analysed (Macann, 1993).

According to Macann (1993) Heidegger perceives phenomenology as letting that which shows itself to be seen from itself. The self-showing begins from Being, the seeing
from Dasein. However, being cannot show itself in the absence of a being to which it can make itself known (Macann, 1993). Dasein cannot see what shows itself the same way as Being lets itself be seen. Phenomenology, therefore, is currently defined as the study of lived phenomenon as they are experienced by human beings. However, Heidegger (Mulhall, 2005), argues that we must bear in mind that ‘the expression “phenomenon” signifies that which shows itself in itself, the manifest.’ These entities (Mulhall, 2005) can show themselves in many different ways: they may appear as something they are not (semblance), or as an indication of the presence of something else that does not show itself directly (symptoms), or as the manifestation of something that is essentially incapable of ever manifesting itself directly.

Heidegger (Mulhall, 2005) emphasises that ‘phenomenology’ names a method and not a subject matter. It is therefore unlike ‘theology’ or ‘methodology’, which offer an articulated, systematic account of what is known about a particular type of entity, region or mode of Being. The next section discusses the most important work by Heidegger that contributed to the phenomenology movement.

**Being and Time (1927)**

This ground-breaking book made its mark over the years on the entire spectrum of the social and the human sciences, from philosophy to psychology, jurisprudence, theology, sociology and literature (Mueller-Vollmer, 1986). Kurian (1994) points out that *Being and Time* was the breakthrough in Heidegger’s philosophical career. The book was published in 1927 and the principal task of this book was to offer an analysis of human existence so that finally the stage could be set for “an interpretation of the meaning of Being as such” (Mueller-Vollmer, 1986, p.33).
Martin Heidegger began his work *Being and Time* by presenting an ontological analysis of Dasein (which essentially means us, human beings) as a way of interpreting the meaning of being and also provided an analysis for the structures of existence. According to Heidegger, the task of ontology is to ‘explain Being itself and to make the Being of entities stand out in full relief’ (Heidegger cited in Healy, 2012).

In introducing *Being and Time*, Heidegger quotes Plato and confirms the general argument that the question of the meaning of Being has passed into oblivion and is no longer addressed and, worse still, when it is addressed it is in such a way that it hides rather that reveals the significance of the question (Macann, 1993). Macann further argues that even though we know what Being means, we no longer know how to address the question of the meaning of Being and that is because we have lost the mode of access to the question.

According to Heidegger, (Mulhall, 2005), the whole of *Being and Time* is concerned with a single question – the question of the meaning of Being. At the beginning of *Being and Time*, Heidegger emphasises that the fundamental nature of Dasein is its existence, and to each one of us our existence is our own. As Heidegger states ‘...Being is in each case mine’ (Heidegger 1962, p. 67).

Wachterhauser (1986) points out that *Being and Time* is not only an attempt to revive the question of Being but is an attempt to develop an ontology of understanding which will create our understanding in our being-in-the-world. Fundamental concepts discussed in *Being and Time*, two of which are described below: Dasein and Being-in-the world which are mutually inclusive, as a discussion of one will not be complete without discussing the other one, and one cannot exist without the other.
**Dasein**

The fact that Heidegger wanted to explore the question of being in his seminal book *Being and Time* was discussed in the previous section. Heidegger approached what was for him the supreme question, which was the meaning of *beingness*, through an analysis of the being which we ourselves are (*Dasein*) (Spiegelberg, 1975).

According to Cerbone (2006), Dasein is the name Heidegger gives for the kind of beings we are. Heidegger, as indicated by Cerbone (2006), used the eccentric phrase *Dasein*, which is composed of *Da-* meaning ‘there’ and *sein*, meaning ‘being’. Heidegger saw in phenomenology the most promising way to uncover the categories of human existence (existentialia) for a fundamental ontology. Since Husserl’s transcendental phenomenology and phenomenology of essence did not seem to be able to answer the question, he developed the new hermeneutical phenomenology whose aim was to interpret the ontological meaning of such human conditions as being-in-the-world, anxiety and care.

Macann (1993) explains that the essence of Dasein lies in its existence. According to Wachterhauser, 1986, the term literally translates as “there-being”, which insists on the dependent situatedness of our condition in space and time. Wachterhauser (1986) maintains that we always find ourselves in a set of spatio-temporal circumstances that are not entirely of our own making and that we cannot leave behind at will. Heidegger argues that living our lives in the particular circumstances which we find ourselves in is accidental, because we are capable of changing these circumstances to some extent; however, what is not accidental but essential of our being is that we will find ourselves in a specific set of circumstances. This means that we cannot avoid the fundamental state of being of our lives. Heidegger states that
we find ourselves “thrown” into a world that disposes of us in various ways and we need to come to terms with that fact. Our experience of ourselves is that we are not autonomous rational agents but we are part of a natural world which is not our creation but on which we are dependent in all our acting and suffering. Wachterhauser (1986, p. 21) is of the opinion that human beings will always have this relationship with the environment: “we can never leave it behind even if we adopt a “disinterested”, theoretical attitude towards it.”

Mulhall (2005) insists that Dasein’s essence lies in existence, and the question of existence can be addressed only through existing, and so that it alone among all entities can be said properly to exist. Dasein does not simply exist but has its being to be. Macann (1993) maintains that having my Being to be means having to take up an attitude towards the very being which is my own; which need not be an authentic attitude. Macann further adds that just because Dasein’s being is an issue for it, Dasein can seek either to come to terms with itself or try to avoid coming to terms with itself; the latter attitude only means that it is itself inauthentically rather than authentically. Spiegelberg (1960) adds that the challenge for Dasein is choosing one of these possibilities, which is to be oneself or not to be oneself (assuming one’s authentic way of being or avoiding it).

Heidegger (Spiegelberg, 1960) uses the word existence differently from all previous usages of the term; the essence of human being lies in its existence, that is, in its ability to choose different ways of beings. After Being and Time, Heidegger introduces the concept of existence as man standing in the clearing of being, as being open to the openness of being or as standing in the midst of being in such a way that he can be in touch with being (Spiegelberg, 1960).

Heidegger’s methodology relates only ‘to the things themselves’ (Spiegelberg, 1960, p. 72) as experienced by us. Heidegger does not accept that his methodology will accidentally
stumble on findings. Instead his aim is to uncover existing phenomena, which indicates ‘the totality of what lies in the light of day or can be brought to light’ (p. 72).

**Being-in-the World**

The concept being-in-the world is different from the being as Ego; therefore, this concept needs a different understanding of the world, not as a physical site of things but as that which is inhabited by humans (Kruger, 1979). Heidegger (1962) identifies being-in-the-world as the inseparableness between human existence and the world. Spiegelberg (1960) maintains that this notion is seen as the basic structure of human being.

Spiegelberg (1960) adds that, for human beings, being cannot take place unless it is in the framework of an encompassing world with which it belongs together and in which it finds itself. The relationship humans have with the world is more intimate and both are what they are because of the relationship they have with each other. The next section explores Heidegger’s involvement with the Nazi regime.

**Heidegger and the Nazis**

Heidegger provoked public controversy over his support of the National Socialist cause in the 1930s and his silence on issues related to the horrors of the Nazi regime (Moran, 2000). Moran claims that Heidegger, who had always been ambitious academically, developed political ambitions in the late 1920s. He sympathised with the Nazi regime and wrote favourably of their principles in his correspondence with Bultman between 1928 and 1932. It is assumed that his wife, Elfride, who was a strong supporter of the Nazis, had a role to play in Heidegger’s tolerance of and stance towards the National Socialist movement.
According to Young (1997), it was Heidegger’s ambition that contributed to his involvement with the Nazis; Heidegger argued that he needed protection from the political party of the Nazi state in order to pursue his aim of making sure that the German Universities were reformed so that academia could play a revitalising role in the cultural life of the German community at large. Victor Farias and Ott are sceptical of these explanations by Heidegger of his involvement with the Nazis (Young 1997). Johnson (2000) maintains that Heidegger believed that National Socialism would address the spiritual causes of the times. He also believed that being the rector of Freiburg University he would be able to reform German Universities in a way that would align them with the spiritual needs of the German people. Moehling (2010) adds that Heidegger insisted on the reassertion of the university and learning in the life of the nation, which would allow the confrontation of vital and urgent spiritual issues. Heidegger (Moehling, 2010) was of the opinion that the German university was the institution of higher learning that had the responsibility of educating and training the leaders and guardians of the destiny of the German people. Moehling (2010) argues that Heidegger’s theory was that the essence of the German university was the will to scientific knowledge and that it was the historical intellectual mandate of the German people.

According to (Moran, 2000), Heidegger wrote several articles calling for a revolution in the German universities to match the National Socialist revolution; he organised militaristic youth camps and was among the first at Freiburg University to introduce the Nazi greeting. Moran further adds that Heidegger gave a number of Nazi propaganda speeches during this period; encouraging people to support Hitler as the only salvation for the Germans. Heidegger failed to defend his old mentor, Husserl, when Husserl was stripped of his official title by Freiberg University, and he went as far as to sign the letter that demanded that non-Aryans be expelled from the University. When Husserl died in 1938, Heidegger did
not attend his funeral, claiming to be ill at the time. However, Heidegger seemed not to be in favour of the pseudo-science of race and biologism (Moran, 2000).

Heidegger, as the head of Freiburg University, introduced the *Fürhrerprinzip*, in terms of which future rectors of the University would be appointed by Berlin. From the aforementioned involvement with the Nazis, Heidegger as a person was in disrepute, but his contribution to philosophy left an indelible mark and Moran (2000) argues that his philosophy should be treated on its own merits. The French phase of the phenomenology movement is discussed in the next section. I have decided to focus on the three most influential philosophers who contributed to phenomenology: Sartre, Ricoeur and Derrida.

**The French phase**

**Jean-Paul Sartre (1905-1980)**

Jean-Paul Sartre was born in Paris in 1905 and, unlike Husserl and Heidegger, did not live an academic life but was an author, playwright and public intellectual (Cerbone, 2006). Moran (2000) points out that Sartre is known far beyond philosophy as a brilliant literary expert, an accomplished novelist and a playwright. Sartre is the Bohemian intellectual who popularised existentialism in post-war Europe and he was also known as a political activist who was a relentless critic of the pretensions of the bourgeoisie and of colonial exploitation in all its forms. Sartre had an interest in politics from an early age and joined the French Communist Party during the Second World War; he defended the Stalinist USSR in his essays and even offered a justification of Stalin’s regime of terror. Sartre’s life was profoundly changed by the Second World War, which contributed to his moving beyond traditional philosophical thinking to thinking in which philosophy and action are connected.
Spiegelberg (1960) notes that Sartre’s versatility and drive defy all conventional classification, and Moran (2000) argues that Sartre’s philosophical interests manifest themselves in the form of a disorderly eclecticism. According to Schrift (2006), Sartre is closely associated with French existentialism, more than any other figure, to such an extent that other existentialists like Gabriel Marcel, Karl Jaspers and Martin Heidegger dissociated themselves from the movement. For example, Marcel and Jaspers distanced themselves from the movement because of Sartre’s atheism; Heidegger’s dissatisfaction with Sartre was due to what he regarded as Sartre’s humanism. Sartre’s interest in phenomenology grew after he attended a lecture by Kojève which explored Hegel’s phenomenology of the spirit (Schrift, 2006).

Barnes (1992) explains Sartre’s perception of being: being in Sartre’s view is the condition of all revelation and for anything to be revealed, for it to be there, it must be. Sartre further adds that consciousness reveals being and to be aware of the object is not the same as being the object. The object does not enter into consciousness any more than consciousness enters into it. According to Sartre consciousness is not a thing. Sartre refers to consciousness as a nonsubstantial absolute. Barnes (1992, p.14) clarifies this:

> Consciousness has nothing substantial, it is pure “appearance” in the sense that it exists only to the degree that it appears. But it is precisely because consciousness is pure appearance, because it is total emptiness (since the entire world is outside it)—it is because of this identity of appearance and existence within it that it can be considered as the absolute.

Sartre argues that the mind is not a thing or substance at all (McCulloch, 1994). Humans do not have minds in the way they have kidneys or other organs but they are minded in that they enjoy a particular kind of psychological interaction with their situation.
According to Barnes (1992) Sartre’s phenomenological declaration assumes that consciousness is consciousness of something. The fundamental opposition on which Sartre builds his ontology is the distinction between the two regions of being which are: being-in-itself and being-for-itself. Both these regions are inseparably associated with consciousness, and the distinction between them is more complex than it appears, and less clear-cut. Being-in-itself refers to non-conscious being and being-for-itself refers to conscious being. Sartre argues that neither consciousness nor non-consciousness exists separately from the other (Barnes, 1992).

McCulloch (1994) explains the misconception that arises from the two kinds of being that Sartre writes about, that is, the being-for-itself and the being-in-itself of consciousness, which are confused by other philosophers as being the same as Descartes’ dualism of mind and body. This dualism assumes that there are material minds, whose essence is to think, and there are immaterial minds whose essence is to be extended in space.

Moran (2000) points out Sartre’s rejection of most of Husserl’s phenomenological methodology, including the reduction. McCulloch (1994) adds that Sartre placed more emphasis on Heidegger’s reaction to Husserl’s phenomenological approach. According to Moran (2000), Sartre insists that it is impossible to carry out a complete reduction because we can never return to objects as they are given to consciousness; the object will always escape the grasp of consciousness or being-for-itself. Sartre further argues that all reduction is imperfect. McCulloch (1994) indicates that Sartre is interested in giving a description of human beings and their world as they appear to consciousness, which is as they are or as they can be experienced.
Moran (2000) maintains that by the mid-40s Sartre’s position as an existentialist had become apparent and he started to pay attention to moments of vertigo, anxiety, nausea and other experiences which were neglected by other philosophers. Sartre argues that there is no blueprint for human existence and according to his existentialism there is no framework that could make life meaningful. Sartre appeals to us to face up to the dizzying formlessness and groundlessness of our existence which provokes feelings.

McCulloch (1994) discusses five theses that Sartre seeks to analyse. The first of these is that all conscious acts have intentionality. Sartre claims that all consciousness is of something; for example, one sees a car, believes that it is raining and imagines one’s children and so on. In all of such consciousness, there is something, a fact or material thing or whatever; of which one is conscious and which features as the intentional object of the conscious episode.

The second thesis is that consciousness is empty. Although Sartre believes that all consciousness episodes suggest intentional objects, he also insists that consciousness itself is empty, it has no contents. This means that there is absolutely nothing in consciousness, not even representations of its intentional objects.

The third thesis is nothingness. As much as Sartre is concerned with being, he is also concerned with non-being and nothingness. Sartre argues that a conscious act is separated from its intentional objects by its nothingness. Consciousness is dissociated from being-in-itself; this dissociation involves other kinds of nothingness, for example, absences and unrealised or unattainable possibilities which determine our experience of the world. My finishing my methodology chapter for my doctoral thesis by next week is a nothingness, since it is only a mere possibility, which will not be realised. The same is meeting with aliens to
discuss the future of the universe. Finishing the methodology chapter by next week is a possibility and is attainable; however, it will remain unrealised as long as I do not work for at least three hours every day on the chapter. On the other hand, the meeting I plan to have with the aliens is no possibility for me at all, no matter what I decide. Therefore, for the kind of being I enjoy and the capabilities I have, the former nothingness enjoys a kind of experiential reality.

The fourth thesis is **freedom**. Sartre considers us to be freer than we think. We choose what sort of world we inhabit; we choose our values. If I choose now to finish the methodology chapter by next week, then I will have to choose again tomorrow and every other day till next week because I always remain free not to do what I have decided. Sartre argues that freedom is similar to the ability to nihilate (to produce nothingness). According to Sartre, being-in-itself remains being what it is. For example, a stone remains being a boring stone. However, being-for-itself changes because a conscious agent is constantly free to reassess and remake itself; and this capacity for self-reassessment in turn contributes to what the agent becomes. Sartre points out that his view of freedom is different from what he refers to as ‘universal determinism’, which is a view that claims that all our actions and choices are caused ultimately by events over which we have no control.

The fifth thesis is that there are **two modes of self-consciousness**. These two modes are being-in-itself and being-for-itself (discussed above). Barnes (1992) declares that being, in Sartre’s view, is the condition of all revelation; for anything to be revealed and for it to be there, it must be and it is consciousness that reveals being. Barnes adds that the most important opposition on which Sartre builds his ontology is the distinction between the two modes of being.
According to Rosato (2010), being-in-itself is the kind of being that appears to consciousness and which is had by other phenomena of the world like tables and lamps. These are the type of being that is described by Sartre as “opaque” and “solid” due to the fact that they do not have a “within” that can be distinguished from a “without”. This, according to Rosato (2010), is the type that does not have self-reference or reflexivity. On the other hand, being-for-itself is transparent and is directed towards a transcendent object. That is why Rosato (2010) suggests that Sartre is of the opinion that the difference between the two modes of being is presupposed by the notion of intentionality.

The next section discusses Ricoeur and his phenomenological stance. Paul Ricoeur’s phenomenological ideas, especially the way he conceptualised textual interpretation, played a very important role.

**Paul Ricoeur (1913-2005)**

Paul Ricoeur was born in Valence, orphaned at the age of two and raised by his paternal grandparents (Schrift, 2006). He enrolled at the University of Rennes and passed his licence in 1933. Ricoeur was captured during the war and spent time in the same prisoner of war camp as Mikel Dufrenne, with whom he became close friends. Together with Dufrenne in the war prison, Ricoeur read the works of Husserl, Heidegger and Marcel. He was mostly interested in the philosophy of Karl Jaspers. In 1950, Ricoeur submitted his doctoral thesis, which was the first volume of his philosophy of the will. Ricoeur taught at College Cèvenol whilst also working as a researcher at the Centre Nationale de Recherche Scientifique; amongst other academic positions, in 1970 he held a professorship in the department of philosophy at the University of Chicago where he taught for several weeks a year.
According to Schrift (2006), Ricoeur was interested in Structuralism when it first appeared on the scene during the 1960s; he got involved with it directly through various critical essays that he wrote. Ricoeur explored both the limitations and the strengths of structuralism and argued that its tendency towards absolute formalism made it look like “Kantianism without a transcendental subject” (Schrift, 2006, p. 174). Schrift maintains that Ricoeur attempted to reconcile what he felt was valuable within phenomenology, hermeneutics and structuralism. From the 1960s to the 1970s, Ricoeur remained one of the staunchest defenders of both phenomenology and hermeneutics.

**Jacques Derrida (1930-2004)**

Derrida was born into a French Jewish family in French colonial Algeria. He went to Paris to study further, and from 1953 to 1954 he studied in the Edmund Husserl archives at the University of Louvain in Belgium. He taught at the University of Paris and was the director of the Collège Internationale de Philosophie, which was founded to provide a public lecture series in philosophy (Stockers, 2007). Apart from his academic work, Derrida also campaigned against apartheid in South Africa, for human rights in Communist Czechoslovakia, and for the rights of migrants and asylum seekers in France. According to (Moran, 2000), Derrida is best known for the intellectual movement that was fashionable in some intellectual circles in the USA during the 1970s and the early 1980s known as ‘deconstruction’. Deconstruction, according to Derrida, always seeks to read and understand (Howells, 1999). Derrida (Howells, 1999) studied phenomenology in Paris with Levinas and Ricoeur, and he considered Hegel, Husserl and Heidegger influential in his philosophical formation. Derrida perceives the phenomenological stance that seeks to ground knowledge in experience as misguided.
Howells (1999) describes Derrida as an unusual philosopher who is hard to categorise because most of his work constitutes an extensive critique of other texts, literary, philosophical, psychoanalytic and political. In all of his work, Derrida has been known as a thorough and patient reader, who seeks to disentangle what has been complex, to bring to light what has been hidden with the aim that what has been relegated to the margins may prove unexpectedly central to a less narrow-minded understanding of the text. Moran (2000) adds that Derrida’s strategy is to call attention to the contexts of texts and to show how meanings are transformed when contextualised.

According to Howells (1999), Derrida has been mistakenly described as a postmodernist or a post-structuralist. Howells is of the opinion that both labels are misleading, because post-structuralism argues that truth claims depend on the discourse or conceptual scheme from where they originate while post-modernism on the other hand argues that all epistemological enterprises, including those of science and philosophy, are simply operative fictions. As far as post-modernists are concerned, even the very questions of relativism and indeterminacy are not truths or falsehoods. This means the “baby of truth has been thrown out with the ‘bathwater’ of positivist certainty” (Howells, 1999, p. 2). Derrida’s aim (Howells, 1999) is not to debunk truth, as he argues that it will be absurd to even think of abandoning truth or meaning.

According to (Stockers, 2007) Derrida began publishing in 1960 and it was in his earlier publications that he voiced his concerns with phenomenology. Derrida was also interested in issues relating to interpretation, law and poetry. He argues that “interpretation is always interpretation of interpretations” (p. 11), since language never disappears to leave us with the reality of what is referred to. Derrida describes the play of interpretations, which is a
play in the linguistic mechanism, not the free play that some of his less rigorous followers tend to believe. The following chapter discusses being from an African perspective.

**Summary**

One needs to keep in mind the different concepts that the two major philosophers in phenomenology use to describe their understanding of phenomenology (Husserlian and Heideggerian phenomenology). Husserl believes that for one to engage in pure phenomenology one has to suspend one’s presuppositions and that it is possible to adopt a presuppositionless stance in relation to the phenomenon. Heidegger on the other hand is of the opinion that history forms a very important part of our being and that we can never suspend what we know when engaging with the phenomenon. Our pre-understanding informs our understanding of the present, and these shape the way we interpret the world. These are the two major differences between the two philosophers. During the discussion of the French phase of the phenomenological movement it has been evident how the three French philosophers drew their thinking from the philosophy of Husserl and Heidegger. The next chapter focuses on hermeneutic phenomenology which was developed in an attempt to interpret Biblical texts, legal documents and literature.
Human civilization differs essentially from nature in that it is only simply a place where capabilities and power work themselves out; man becomes what he is through, what he does and how he behaves....

Chapter 9

Hermeneutic Phenomenology

The previous chapter dealt with phenomenology in general and the different ways in which different philosophers have conceptualised the notion. I also indicated in the previous chapter that I have chosen to use the Heideggerian view of phenomenology for this study; therefore, I felt that it was important to give a comprehensive description of Heidegger’s philosophy in terms of phenomenology and interpretation of text; hence the inclusion of this chapter in the study.

Hermeneutic phenomenology is a blending of the two philosophical traditions, hermeneutics and phenomenology. Schleiermacher and Dilthey are the two notable philosophers in the hermeneutic tradition (Kurian, 1994). Hermeneutics is a term that has been debated about a great deal, so much so that it is used in many different contexts with many different meanings (Wachterhauser, 1986). The discussion of hermeneutics begins with an exploration of the historical background of hermeneutics as suggested by Palmer (1969). The next section examines the definition of hermeneutics. The concept of language, history, hermeneutic circle and presuppositions are also explored.

Historical Background

Mueller-Vollmer (1986) suggests that the art of interpretation has been under scrutiny and performed in different ways since antiquity. Mueller-Vollmer (1986) maintains that hermeneutics became an integral part of theological culture during the Middle Ages; however, it was not until the Renaissance, the Reformation and the later years that hermeneutics became a special discipline. Moran (2000) discusses the historical background
of hermeneutics based on the different eras: during the Middle Ages and the Renaissance, hermeneutics was applied for the interpretation of legal documents. However, it was the religious Reformation that brought about the vast expansion of hermeneutics; the Protestant and the Catholic theologians argued over the principles to be applied in interpreting Biblical texts. Moran adds that the Enlightenment and the Romantic era saw the emergence of hermeneutics as a teachable skill or art. It was during this era that philosophers like Chladenius (1710-1759) and Schleiermacher (1768-1834) laid the foundation of hermeneutics as it is currently known.

Palmer (1969) on the other hand discusses the three philosophers who according to him paved the way for hermeneutics. Friedrich Ast (1778-1841) and Friedrich August Wolf (1759-1824) are perceived by Palmer (1969) as fore-runners of Schleiermacher, and Palmer indicates that in order to appreciate the nature and magnitude of Schleiermacher’s (1768-1834) contribution to the development of hermeneutics it is important that one consider the state of hermeneutics of his time and the conception of the field as formulated by Ast and Wolf. The next section is Palmer’s (1969) discussion of the fore-runners of hermeneutics.

**Friedrich Ast (1778-1841)**

According to Palmer (1969), Ast’s main aim was to grasp the spirit of antiquity through language. Language is used as the prime medium for transmission of the spiritual. Palmer maintains that in order to study the writing of antiquity we need grammar. Ast argued that the “study of ancient languages must always be bound in hermeneutics” (Palmer, 1969, p. 76). Ast understood hermeneutics as the theory that extracts the spiritual meaning of the text. This formed the basis of Ast’s hermeneutical circle which originated from the spiritual unity of the humanities. Ast believes that hermeneutics has three tasks which aim to clarify
the work to be interpreted, through the development of its own meaning internally and how the inner parts relate to each other and to the larger spiritual age. Ast (Palmer, 1969) describes the tasks thus:

1. The historical; this focuses on understanding of the content of the work, be that scientific, artistic or general.
2. The grammatical; this pertains to linguistic understanding.
3. The “Geistige”; this focuses on understanding the author’s view of the work and the Geist, which is the total view of the age.

Ast believed that the above levels form the fundamental part when engaging with the text. Keeping the above factors in mind enables one to have a holistic view of what is in the text.

Friedrich August Wolf (1759-1824)

According to Wolf, hermeneutics is defined as the science of rules by which meaning of signs is recognised (Palmer, 1969). Wolf was the more colourful of the two and his work was not as systematic and organised as that of Ast. Wolf maintains that rules differ with the object of interpretation; therefore, there is hermeneutics for different objects, that is, for poetry, history and so on. The rules of these different objects should be arrived at through practice and this makes hermeneutics a practical endeavour instead of a theoretical one. According to Wolf the aim of hermeneutics is to understand the written or the spoken thoughts of an author as he would have them grasped. Wolf adds that interpretation is a dialogue with the author, and the aim of hermeneutics is an effort at perfect communication. The following are qualities that, according to Wolf, an interpreter should have:

1. General talent for empathising with the thoughts of others.
2. That lightness of the soul which adapts itself to foreign thoughts.
Wolf argues that for hermeneutics to be possible, an interpreter should have an aptitude for dialogue and the ability to enter into the mental world of another person. Like Ast, Wolf maintains that explanation must be grounded in understanding and that understanding is not explanation. Wolf’s three-step hermeneutics is slightly different from Ast’s; however, it is a lot more practical. The following are the three levels: grammatical: this is the level that explores what language is able to do to facilitate interpretation; historica: this is the second level that is concerned with historical facts of the time, this goes together with the factual knowledge of the author’s life; and philosophica: this is the last level which checks and controls the former two levels. The next section examines Schleiermacher, who is seen as the founder of modern-day hermeneutics.

Schleiermacher (1768-1843)

Everything is understood when nothing nonsensical remains.

Nothing is understood that is not construed.

Friedrich Schleiermacher, Notes, 1809 (Mueller-Vollmer, 1986, p. 8)

Mueller-Vollmer (1986) describes Schleiermacher as the philosopher who brought together the major developments of hermeneutics from the older schools and set the groundwork for the hermeneutic philosophy of the 19th and the 20th centuries. Schleiermacher was a theologian and was inspired by the ideal pioneered by the German Romantic Movement.

According to West (1979), Schleiermacher is seen as the founder of modern hermeneutics; he shifted the focus of hermeneutics from understanding text to the process of understanding itself. Thiselton (2006) adds that Schleiermacher’s work constitutes the turning
point in the history of hermeneutics. According to Thiselton (2006), before Schleiermacher, hermeneutics sought to support and clarify an already accepted understanding.

Schleiermacher’s hermeneutics concerned itself with the formulation of rules, which ensured that a particular understanding of the text is an accurate one. Moran (2000, p. 274) quotes Gadamer as saying:

Schleiermacher defined hermeneutics as the art of understanding. To exclude by controlled methodical consideration whatever is alien and leads to misunderstanding, suggested to us by distances in time, change in linguistic usages, or in meanings of words and modes of thinking…

According to Palmer (1969), Schleiermacher described in one sentence what the fundamental aim of hermeneutics is: to frame a general hermeneutics as the art of understanding. This art, Schleiermacher argues, is to be the same regardless of what type of text is being interpreted; be that a legal document, religious scripture or literature.

Schleiermacher (Palmer, 1969) acknowledged the fact that there are differences among these various kinds of text; however, beneath these differences there ought to be a fundamental unity. Palmer (1969) discusses the fundamental unity of any text as perceived by Schleiermacher: Texts are in language and the meaning of a sentence is arrived at using grammar; the general idea interacts with grammatical structure to form meaning regardless of what type of document is interpreted.

For the original meanings of the text to be uncovered, Schleiermacher developed a theory about the manner in which tradition is grounded in history; this also included the psychological theory that focused on the nature of human behaviour and motivation (Moran, 2000). Schleiermacher (Moran 2000) insisted that interpretation of text ought to take place at
two different levels: the grammatical and the psychological interpretation. West (1979) maintains that these two interpretations are the two moments of reconstruction, and understanding can only take place when there is a synergy between the two moments. Grammatical interpretation according to West (1979) occurs when the historical context, linguistic discourse and meanings of the author are reconstructed. This interpretation explores the zeitgeist of the era in which the author writes; it is “the intellectual, emotional and the personal stage of the author’s development; the literary genre which the author adopts; and the semantic possibilities of the words that the author employs” (West, 1979, p. 73).

West (1979) adds that there are two principles in grammatical interpretation: the first principle seeks to determine claims, insights and statements in the author’s text based on the use of language which is common to the author and his original public; the second principle seeks to determine the single meaning of the words in the author’s text based on the context in which it takes place.

According to West (1979), the psychological interpretation is Schleiermacher’s original contribution to hermeneutics. Psychological interpretation is described by Schleiermacher as the reconstruction of the author’s style, subjectivity, individuality and uniqueness. “This interpretation delves into the inner chambers of the author, viewing the author’s text as the expression and manifestation of what goes on within these inner chambers” (West, 1979, p. 73).

West (1979) notes that, like the grammatical interpretation, the psychological interpretation consists of two kinds: the technical and the psychological proper interpretations. The first one focuses on reconstructing the particular circumstances and details which influence the uniqueness of the author’s text. The psychological proper
interpretation entails two interpretive procedures: the comparative and the divinatory procedures.

**Definition of Hermeneutics**

The word hermeneutics is thought to originate from *hermeneia*, which is related to the Greek god Hermes, a messenger and trickster who carried messages from the gods to the people (Addison, 1992). His role was to interpret these messages and render them comprehensible to humans. Hermes makes manifest the divine thoughts, translates the infinite into the finite. The essence of *hermeneia* consists of what the Romans called, *elocutio*, which is the expression of thought and not the understanding. Therefore, *hermeneia* signified the rendering of one person’s language intelligible to the other, the work of the interpreter (Mueller-Vollmer, 1986). Tracing them back to their earliest known root words in Greek, the origins of the modern words “hermeneutics” and ‘hermeneutical” thus suggest the process of ‘bringing to understanding”, as this process involves language (Palmer, 1969). The verb *hermēneuein*, is generally translated as “to interpret,” and the verb *hērmeneia* as “interpretation” (Palmer, 1969, p. 12). Palmer discusses the three directions of *hermēneuein*which may be expressed by the English translation “to interpret”, as each direction constitutes an independent and significant meaning of the word “interpretation.

Hermeneutics is an ancient discipline which was originally concerned with interpretation of early religious text; it was seen as a method for discovering correct meaning from several different versions of the same text (Reason & Rowen, 1981).
Heidegger and Hermeneutics

The section entitled ‘The Phenomenological Method of Investigation’ in *Being and Time* discusses a method that Heidegger refers to as hermeneutic (Palmer, 1969). Kurian (1994) indicates that Heidegger’s collaboration with Husserl played a very important role in his life; the mentorship that Heidegger got from Husserl was very inspiring, and he found that the phenomenological insights of Husserl made it possible for him to carry out his inquiry into the meaning of Being. Heidegger was an attentive student and was responsive to Husserl’s training in phenomenological seeing and this required that he reject the untested use of philosophical knowledge.

Kurian (1994) notes that it was during this time that Heidegger developed an interest in the study of the text and the technique of interpretation. This interest in textual exegesis was the beginning of a line of thought that led to hermeneutic phenomenology. Heidegger’s leaning towards hermeneutics was first observed during the lecture that he gave at Marburg University in 1927, which was later published as *The Basic Problems of Phenomenology*.

Gadamer and Heidegger argue that “trying to understand, taking meaning from or making intelligible that which is not yet understood is not only the central task of hermeneutics, it is a central aspect of our being in the world” (Addison, 1992, p. 110). Hermeneutics has as its starting point the fundamental belief that we cannot apprehend human experience without understanding the factors, be they social or linguistic, which give it shape (Terre Blanche & Kelly, 1999). Hermeneutic understanding cannot be applied from the outside; it is assumed that the interpreter “knows” to some extent the phenomenon he/she seeks to understand (Reason & Rowen, 1981).
Martin Heidegger, who was Husserl’s student, rejected the theory of knowledge known as epistemology, and adopted ontology, the science of being (Creswell, 1998). Heidegger developed interpretive phenomenology by extending hermeneutics, the philosophy of interpretation, and he broadened hermeneutics by studying the concept of being in the world rather than knowing the world. Hermeneutics moves beyond the description or core concepts of the experience and seeks meanings that are embedded in everyday occurrences (Lopez & Willis, 2004). According to Spiegelberg (1960) the goal of hermeneutic phenomenology is to discover meanings that are not immediately manifest to our understanding, analysis and describing; the interpreter goes beyond what is directly given by using the given as a clue for meanings which are not explicitly given.

Wachterhauser (1986) indicates that hermeneutic thinkers can be categorised generally by their common concern to resist the idea of human intellect as a wordless and timeless source of insight. These thinkers insist that human intellect does not have the capacity for a pure seeing of reality in itself; they argue that all human understanding is never without words and never outside of time. Language and history are, therefore, both conditions and limits of understanding; these two themes are said to run like dual strands throughout the hermeneutical literature. Kurian (1994) adds that all understanding occurs within a temporal framework and there is no understanding outside time; our historicity remains as a conditioning principle for all aspects of our life. This means that truth has to be determined contextually by taking into consideration the ideal and the practices of the present. Thus no understanding can take place in a historical vacuum (Kurian, 1994). A description of hermeneutics and language will be explored in the next section.
Language and history

*Our enquiry has been guided by the basic idea that language is a medium where I and the world meet, or rather, manifest their original belonging together.*


In *Being and Time*, Heidegger associates language with reason and sees it as a principal source of our pre-understanding (Wachterhauser, 1986). Language makes it possible for us to identify things as belonging to certain historically different classes; this enables us to think of them in general and shared terms. Wachterhauser indicates that language and reality are mutually beneficial and that changes in the world require change in language. On the other hand, change in language affects what we are able to grasp about the world.

According to Humboldt (1767-1835), understanding is the basic characteristic of human behaviour and is linked to man’s capacity for speech and to the nature of language (Mueller-Vollmer, 1986). Humboldt describes language as a social and intellectual activity; language as a phenomenon develops only in social intercourse. Humans understand themselves by testing the comprehensibility of their words on others. As language is transmitted to others, it becomes associated with the common heritage of the entire human race. Heidegger argues that the hermeneutical function of language is to bring something to light; the true foundation of language is the phenomenon of speaking (Palmer, 1969).

According to Gadamer (Wachterhauser, 1986), all thought is linguistic and although thinking may not be reducible to language or linguistic behaviour, it is inseparable from it. Language is a medium within which we move and understand ourselves and the world from different perspectives. As a medium, language should not be understood as a straightjacket
but as an inter-subjective fabric of semantic relations that both makes possible and limits understanding.

Palmer (1969) maintains that language is not fixed and rigidly certain; it is constantly moving, shifting and fulfilling its mission of bringing a thing to understanding. For example, currently language has evolved to accommodate text messaging; the language used by the younger generation when texting is totally different from what is used by the older generation. Our understanding of a phenomenon varies in complexity and depth depending on the number of ways we have of speaking about it.

Palmer (1969) further reminds us that the formation of words is the product not of reflection but of experience; language is an expression not of spirit or mind but of situation and being. According to Moran (2000), Gadamer, consistently with Heidegger’s thinking, maintains that language in a sense encompasses human experience. Gadamer suggests that it is through language that we have a world and it is through language that a set of common repeatable meanings emerges that enable us to share with others a common sense of what the world is about; without language, the world is unintelligible (Wacheterhauser, 1986).

Palmer (1969) argues that the world is not impersonal nor does it circle an isolated individual; the world is between persons where shared understanding takes place through language. Gadamer insists (Moran, 2000) that language not only reflects human being but actually makes human be; it brings about human existence as shared understanding and self-understanding. Heidegger (Wright, 1986) points out that language is a medium of communication and a common inheritance from the culture or society into which a given Dasein finds itself thrown; this means that language allows Dasein to express itself.
Heidegger further argues that language allows us to communicate about things in the world; language allows us to say something about something.

According to Cerbone (2006), the rules of language, although not set in stone, are sustained by the collective conformity. This general agreement allows individuals and communities to decide what makes sense for them. In *Truth and Method*, Gadamer agrees with Heidegger that language has its true being only in conversation and in the exercise of understanding between two people (Wright, 1986).

Mulhall (2005) puts forward Heidegger’s view that everyday linguistic communication consists of idle talk, which is a form of average language intelligibility. Heidegger further maintains that all talk involves both an object, which is what the conversation is about, and a claim about it. In idle talk, we are concerned more about the claim relating to the object than the object itself; and instead of trying to gain genuine access to the object as it is in itself, we concentrate on what is claimed about it. This stance results in our taking for granted that what is said is so, simply because it is said so. Essentially what we seem to understand about what is talked about consists of what we think of ourselves as understanding just when we fail to do so. Therefore complete understanding that emerges from idle talk closes off its objects rather than disclosing them, thus resulting in the closing off of the possibility of future investigations about them. Wrathall (2011) argues that in idle talk one understands things only superficially and one listens to what is said in conversations without understanding the entities that are being discussed; this kind of conversation releases one from the task of understanding. Heidegger perceives idle talk as a pervasive phenomenon which accounts for his belief that language itself is essentially limited to public norms of understanding and interpretation (Wrathall, 2011). This is a phenomenon that happens all the time in our everyday interactions with others. When we take for granted what it is like to
have schizophrenia, it robs us of the opportunity to learn about the real experiences of having schizophrenia and it also robs those diagnosed with the illness of being understood.

Bontekoe (1996) maintains that word alone gives being to the thing. Humans continually find themselves thrown into a world alongside entities and with other human beings; however, the involvements we have with other human beings are always accompanied by a language appropriate to us. According to Bontekoe, there is a language for family, modern technology, mental health and so on. The language that is used defines the relevant range of involvement, which opens up the conceptual space for the innovation question; this enables us to recognise the thing in question when we encounter it. For example, having conversations with invisible people and seeing invisible people is called auditory and visual hallucinations. Therefore, language has made it easier for people to recognise visual and auditory hallucinations when they occur. They became noticeable as hallucinations only when a word was coined to describe them. Heidegger observes: “language alone brings what is, as something that is, into the open for the first time” (Bontekoe, 1996, p. 90). Bontekoe argues that if language has this power of bringing what is into the open, we need to approach it attentively and respectively. It is not just a medium of expression but it is language itself that speaks to us about the world. Graybeal (1990) agrees that language is more than just a means, it is a creative force in itself; it gives birth to and brings to the open what is.

Gadamer reminds us that language can never be a neutral simple window on experience; it is already coloured with the value system of the culture which supports it and whose language in turn brings it to life (Moran, 2000). According to Gadamer, every effort to speak or comprehend carries the baggage of the cultural and the educational tradition; however, even though our understanding arises out of our tradition and its prejudices, this
does not mean that we remain trapped within our own subjective point of view (Moran, 2000). Palmer (1969) argues that the power of language to order and form thought is not a matter of the rigidity in language; instead the power is grounded in the situation that language communicates. Therefore, language is not a prison but an open space in being that permits an endless growth, depending on one’s openness to tradition.

Moran (2000, p. 282) argues that even though Gadamer’s famous statement “being that can be understood is language” was perceived by others as some sort of linguistic idealism, Gadamer did not imply in a post-modern deconstructionist way that only language exists, but rather in phenomenological terms that language is the mode of manifestations of being. Gadamer insisted that things other than language come to exist through language. Heidegger (Palmer, 1986) argues that if our essence did not include the power of language, then an understanding of humans would be challenging and without language man could not be imaginable to us.

According to Wachterhauser (1986), what is distinctive about human understanding is that it is always in terms of some evolving linguistic framework that has been worked out over time regarding some historically conditioned set of concerns and practices. For Gadamer (Mueller-Vollmer, 1986), understanding and interpretation constitute the mode of being of all our cultural traditions. These traditions are embedded in language (die Sprache). Therefore, understanding and interpretations are events in an historical process.

History and language are the two themes that (Wachterhauser, 1986) run like dual strands throughout the hermeneutical literature. The next concept, presuppositions, forms a very important part of hermeneutics. Hans-Georg Gadamer in Truth and Method insists that the horizon of the present cannot be formed without the past.
Presuppositions

Mueller-Vollmer (1986) discusses Bultmann’s debate regarding the possibility of exegesis without presuppositions. According to Bultmann, as we have certain ideas of the subject matter with which the text is concerned, we approach the text with specific questions or with specific ways of raising questions. Therefore, exegesis without presuppositions is not only impossible but is demanded; the exegete is not a tabula rasa. Historical understanding always presupposes a relation of the interpreter to the subject matter that is expressed in texts. Bultmann challenges interpreters to be open about their presuppositions or pre-understandings when interacting with the text. The historical picture of the text will be falsified only when the interpreter takes their pre-understanding as definitive understanding. Mueller-Vollmer (1986) points to Bultmann’s view that understanding history is only possible for those who do not stand over it as neutral, non-participating spectators, but stand in history and share in responsibility for it. This encounter with history that grows out of one’s historicity is known as the existentiell encounter; the historian participates in it and is part of that history. This does not mean that understanding of history is subjective but history in its objective content can only be understood by a subject who is existentiell moved and alive.

According to Palmer (1969) each interpretation of history or a historical document is guided by a certain interest which in turn is based on a preliminary understanding of the subject. Bultmann further states that out of this interest and understanding, the questions to be raised are developed. Without these, no questions will be raised and no interpretation will follow. Therefore, all interpretation is guided by the subject’s pre-understanding. In a sense, a historian always chooses a certain viewpoint and regardless of how objectively he may
pursue his subject, the historian cannot escape his own understanding. In choosing a viewpoint, an existential encounter occurs with history. Heidegger’s conception of the pre-structure of understanding accepts that we understand a given text, matter or situation because we hold in our understanding, and bring into play, a preliminary intention with regard to the situation: an already established way of seeing, and certain ideational preconceptions.

Furthermore, Gadamer’s critique of historical consciousness argues that the past is not like a pile of facts which can be made an object of consciousness, but rather a stream in which we move and take part. Thus, tradition is not against us but something in which people stand and through which they exist (Palmer, 1986).

The Hermeneutic Circle

*Understanding always begins in media res, that is that which has already been understood always forms the basis for grasping that which still remains to be understood* (Bontekoe, 1996, p. 2)

Before the 19th century, there were many individuals, professors and students of law, history and classical literature who were concerned with the interpretation of the written word and who had insightful things to say about how to approach texts (Bontekoe, 1996). Schleiermacher was the first philosopher to discover the structure of the hermeneutic circle. After Schleiermacher, hermeneutics progressed exponentially. Towards the end of the 19th century, Dilthey and other philosophers recognised the possibility of using Schleiermacher’s principles of textual interpretation in the study of history. A few decades later, Heidegger used hermeneutics as a method which could be applied to the study of fundamental ontology.
This marked the turning point for hermeneutics, as Heidegger demonstrates that human understanding is ruled by the structures of the hermeneutic circle. Consequently Gadamer, who was a former student of Heidegger’s, explored how textual interpretation and history is now understood. *Truth and Method*, which was published in 1960, remains the most important work in the field of hermeneutics (Bontekoe, 1996).

According to Schleiermacher (Bontekoe, 1996), hermeneutic interpretation has two sides: the grammatical and the technical (psychological). The grammatical is concerned with establishing how speech or the text in question is to be understood in terms of the context provided by the language within which it spoken or written. The grammatical is based on things such as vocabulary, punctuation, sentence structure and genre; this includes an understanding of how these features of language have changed. The technical or the psychological side is concerned with establishing how the speech or text in question fits with the context of its author’s intellectual life. Thus, an inquiry into the author’s biography and an examination of the social conditions of the time and place in which she/he lived is required in order to uncover influences on and tendencies in the author’s thinking.

The hermeneutic circle involves the contextualised claim that the parts of some larger reality can be understood only in terms of the whole of that reality and that the whole of that reality can be understood only in terms of its parts. To understand any phenomenon, firstly, it has to be situated in a larger context in which it has its function; this also means letting our understanding of that particular phenomenon influence the understanding of the whole context (Wachterhauser, 1986).

Wachterhauser (1986) suggests that this circular relation is meant to describe a structural feature of the way in which human knowledge evolves within a given historical-
linguistic framework without jumping out of that framework in a great leap of reflection. The hermeneutic circle reminds us that there are no truly new beginnings. Heidegger points out that just because we grasp reality from this or that historically mediated perspective and just because all understanding happens in a hermeneutic circle that does not allow us to assign meaning to reality arbitrarily. The hermeneutic circle thus demands that we come into the circle in the right way and it prohibits us from avoiding the hard empirical work of learning how things really are in the world; the hermeneutic circle is a finite discovery of how things are from a particular point of view at a particular time. Heidegger adds that meaning is not arbitrarily imposed from outside nor is it discovered as a fact; rather it is worked out in a finite historical context in a dialectical fashion.

Bontekoe (1996) points out that all human understanding is hermeneutically circular because of its taking place in a specific time (that is, its temporality). Bontekoe, in explaining this circularity of human understanding, maintains that humans are always located at some point in time during a specific moment in time, which makes information that is available to us serial. As humans, we are aware of things in succession, which means that one item after the other becomes available to us. This sequential appropriation of information is a matter of immediate perception and does not constitute understanding.

Bontekoe (1996) further notes that understanding takes place only when we recognise the importance of the various items that we notice; that is, when we become aware of the relatedness of these items. Understanding is therefore an integrative activity. Below is a diagrammatic representation of the hermeneutic circle:
Bontekoe (1996) explains the above diagram that represents the hermeneutic circle as follows: The circle has two poles that comprise the object comprehension which is considered as a whole. The other pole consists of the various parts of which the object of comprehension is composed. The left hand arrow indicates that the object of comprehension taken as a whole is understood in terms of its parts. This understanding involves the recognition of how these parts are integrated in the whole. The parts once integrated define the whole. The right hand arrow indicates that the individual parts of the object of comprehension are understood in terms of their participation in the whole, and thus understanding involves the recognition of how the whole contextualises each of its parts. In the process of contextualisation, each of the parts is illuminated in its own integrity. The parts are what they are by virtue of their being here and consequently serving this function within the whole. The two poles of the hermeneutic circle are therefore bound together in a
relationship of mutual clarification. According to Schleirermacher and Heidegger, (Thiselton, 2006) we can understand a whole only in light of its parts.

Bontekoe (1996) argues that there is constant augmentation of information in the hermeneutic circle, which may enter the circle at either or both of the poles; this results in progressive development of new insights. In essence, the hermeneutic circle reflects the way in which the structure of human understanding is dictated by the historical nature of our experiences. Thiselton (2006) adds that a leap into the hermeneutic circle takes place when we understand the whole and the parts together. This, Palmer suggests, is an area of shared understanding (Thiselton, 2006).

Gadamer (1975) believes that the interplay of partners in dialogue has the potential to generate shared meaning through what he calls the “fusing of horizons”. This “fusing” occurs because the horizon of tradition, the interpreter of a text, or the listener to dialogue, belongs to and is conditioned by their culture, or as Gadamer would argue, their horizon of tradition. Gadamer insists that all interpretations are embedded in our social and individual histories. These histories or pre-understandings enter into any dialogical situation with us for they serve as the foundations for our values, assumptions, and relationships.

**Phenomenology and Psychopathology**

This study focuses on schizophrenia and it seemed appropriate to discuss how phenomenology and psychopathology are related. This section seeks to explore how the two, that is, phenomenology and psychopathology, can be brought together.

The increased growth of the neuro-scientific paradigms in psychiatry has led to renewed challenges for clinicians and researchers by combining objective knowledge of brain
functioning with the subjective experiences of schizophrenia (Stanghellini, Bulton & Fulford 2013). Stanghellini et al. (2013) maintain that during the early 20th century, Karl Jaspers’ main focus was on the importance of meanings as well as causes in psychopathology. Jaspers argued that psychiatry is about people not brains, therefore, it has to deal with three aspects: firstly, it has to deal with subjective experiences as well as neuro-biological dysfunctions; secondly, it has to deal with personal meanings of psychoses for the individual concerned as well as their causes; and lastly, it has to deal with personal individual features of the illness as experienced by people who are diagnosed with mental illness.

**Jaspers and Phenomenology**

Karl Jaspers had the greatest influence on psychiatry (Mullen, 2007). According to Mullen, Jaspers was influenced by the phenomenological movement and as a philosopher his stance leaned more towards the existential tradition of Nietzsche and Kierkegaard. Jablensky (2013) gives the following short biography of Karl Jaspers:

Karl Jaspers (1883-1969) was a psychiatrist at the Heidelberg University Klinik. Jaspers was openly opposed to the Nazi regime which resulted in his being deprived of his academic chair in 1937 and subsequently banned from lecturing and publishing in Germany. He became professor of philosophy in Basel from 1948 until his death. Jaspers was inspired by Husserl’s phenomenology and Dilthey’s theoretical psychology. He used Husserl’s descriptive psychology as a method of systematic articulation of subjective mental states as experienced and described by patients; Dilthey’s distinction between genetic (empathetic) understanding of the connectedness of subjective experiential content and the objective explanatory models was influential in his thinking.
Jablensky (2013) clarifies Jaspers’ understanding of phenomenology as a method of bringing to conceptually clear consciousness and of characterising mental processes as they really are by analysing the subjective self-descriptions of patients. In an attempt to justify the subjective reality as the immediate given which is experienced by the patients, phenomenological analysis brackets out any assumptions about their accepted causes in brain physiology and unconscious mechanisms. This creates a set of concepts and categories in which the subject’s experience is fixed and can be communicated. The outcome of this analysis creates a theoretical framework of psychopathology as experienced by patients (Jablensky, 2013).

Stanghellini et al. (2013) point out that the experiences of people with schizophrenia include three distinct domains: the person’s phenomenological world, which includes all forms of subjective experience; secondly, their sense of pre-reflective self and thirdly, the person’s existential orientation and attitude toward their illness.

Parnas, Sass and Zahavi (2013) argue that psychiatry should set aside any explanatory or therapeutic ambition and focus on the observational and descriptive task; it is only through this exercise that is possible to grasp what it is that needs to be treated. Jaspers (Parnas et al., 2013) emphasises the importance of applying well-differentiated concepts or presuppositions which form part of understanding. According to Jaspers (Stanghellini et al., 2013), there are two kinds of knowledge needed regarding the patient’s abnormal experiences: firstly, there is objective knowledge which is rooted in the medical model; this model understands schizophrenia as being caused by a morbid process. This is the kind of knowledge in which researchers and clinicians are proficient. The second kind of knowledge is the more personal kind of understanding resulting in meaningful actions.
Parnas et al. (2013) insist that observing a person with psychotic symptoms is not enough; therefore, Jaspers argues that to be able to take the full range of psychic reality, the sensitive phenomenological interviewer must take note of her considerable knowledge of abnormal and normal psychology. The phenomenological approach to psychiatry appeals to us to be vigilant of the over-simplification of the experiences of people with mental illness based on our reliance on methodologies; for example, the structured interview used by mental health providers is unable to capture the subtle forms of experience and expression that constitute the essential psychiatric object.

According to Mullen (2007), the phenomenological approaches to psychopathology consider and study human experience and behaviour in a way that does not start from prior theories or assumptions. In psychopathology, the aim is to understand the nature of the experiences before they are lost in futile debates about the meanings and definitions of the words that others use to describe those experiences. Tatossian (1979) points out that phenomenology as applied in psychiatry does not pretend to be able to explain anything; rather, it claims to be able to provide an enlightenment into the psychiatric experience. “It is no so much bringing to light new states of affairs, but rather providing new insights into the established ways of looking at experience” (Tatossian, 1979, p. 11). Stanghellin (2011) adds that phenomenological psychopathology brings to light deeper phenomena, compared to the surface symptoms on which contemporary nosography is based. Phenomenological psychopathology is merely the cataloguing and study of mental symptomatology but is an attempt at understanding individuals and types of human existence.

Stanghellin (2011) maintains that phenomenology challenges the core assumptions of current psychiatry by overcoming the narrow conception of the person as an enclosed individual with a clearly defined brain dysfunction. Phenomenology recognises the ways in
which the disorder is being shaped by the patient’s intersubjective and socio-historical situation. Consistent with Heidegger’s description of Being, a person is inseparable from their being-in-the-world and being-with-others; however, mental illness is something that manifests itself in a change of the person’s being-in-the-world and the person’s relations with others (Stanghellin, 2011).

Mullen (2007) further indicates that the term phenomenology has various meanings in psychiatric literature:

1. Phenomenology is understood as the precise definition of psychiatric symptoms. This merges with the operational technology which forms an important part of the diagnostic classification in psychiatry such as the DSM, which imposes definition in the name of consistency, reproducibility and case communication.

2. Phenomenology as a way of describing experiences and actions of patients and where an attempt is made to give an account of their experiences without imposing pre-existing assumptions. This method is similar to Husserl’s transcendental reduction, which means assuming that what is described exists in isolation from the rest of the world, free from questions of context, significance and type.

3. Phenomenology which attempts to derive the essential meaning of experience in a process called eidetic analysis.

4. Phenomenology in which the inner world of the other is understood through analysis of categories of experience, such as time, space and materiality. It does not confine itself to the description on the way to clinical understanding but changes into a joint project between patient and clinician. This results in meaningful understanding of the experiences and it goes beyond the distress and the disorder of their existence.
The above discussion of phenomenology in psychiatry seeks to sensitise the mental health care workers to the importance of validating the experiences of those diagnosed with mental illness. The significance of diagnostic categories is noted; however, they should not be the only focus when interacting with patients.

**Phenomenology and Research**

Halldórsdóttir (2000) notes that phenomenology is not a unified body of thought and there are diverse interpretations and conceptualisations of phenomenological philosophy and its application in research. Lindseth and Norberg (2004) describe phenomenology as an inductive qualitative research tradition rooted in the 20th-century philosophical traditions of Edmund Husserl (descriptive) and Martin Heidegger (interpretive). When Husserl founded phenomenology about 100 years ago, his starting point was the experience that science was preoccupied with explaining natural objects or events, whereas the understandable meaning of these objects and events was taken for granted within the framework of natural research and received little attention (Lindseth & Norberg, 2004).

Applied to research, phenomenology studies phenomena, which include its nature and its meanings (Finlay, 2008). Finlay (2008) adds that phenomenological research provides a richly textured description of lived experience. Groenewald (2004) explains Giorgi’s stated aim of phenomenological research which is to describe as accurately as possible the phenomena under study. Giorgi adds that the researcher should be aware of his presuppositions and should seek to remain true to the facts. Groenewald (2004) further argues that researchers who use the phenomenological framework are concerned with the lived experience of the people.
Lester (1999) is of the opinion that pure phenomenological research seeks to describe rather than to explain. The researcher starts from a view free of preconceptions, if subscribing to Husserlian phenomenology. If the Heideggerian phenomenological view is adopted, the researcher should always be aware of their pre-understandings of the phenomena under study. Lester (1999) insists that phenomenological methods bring forth experiences and perceptions of individuals from their own perspective.

Laverty (2003) suggests that phenomenological research is not only descriptive but also focuses on the structure of experiences; this also acts as an organising principle that gives form and meaning to the life world. Laverty adds that phenomenology seeks to clarify the essences of these structures as they appear in consciousness, thereby making what is invisible visible. While all phenomenology is descriptive in the sense of aiming to describe rather than explain, a number of scholars and researchers distinguish between descriptive phenomenology versus interpretive, or hermeneutic, phenomenology. Descriptive (Husserl-inspired) phenomenology, aims to reveal essential general meaning structures of a phenomenon. It stays close to what is given in all its richness and complexity, and restricts itself to “making assertions which are supported by appropriate intuitive validations” (Mohanty, 1983, cited in Giorgi, 1986, p.9).

According to Halldórsdóttir (2000), phenomenology is both a philosophy and a methodology and is part of the constructivist/interpretive paradigm. Interpretive phenomenology emerged from the work of hermeneutic philosophers, like Heidegger, Gadamer, and Ricoeur, who argue for embeddedness in the world of language and social relationships, and the inescapable historicity of all understanding. Heidegger argues that “...the meaning of phenomenological description as a method lies in interpretation” (Finlay, 2008, p. 11). The interpretive paradigm (Crotty, 1998) assumes that meanings are constructed.
by human beings in unique ways, depending on their context and personal frames of reference as they engage with the world they are interpreting. Crotty adds that this is the notion of multiple constructed realities. In this type of research, findings emerge from the interactions between the researcher and the participants as the research progresses (Creswell, 1998). Halldórsdóttir (2000) adds that phenomenological researchers study the ordinary life-world and they are interested in how people experience their world and what it is like for them. Halldórsdóttir (2000) points out Husserl’s view that phenomenology does not create but only finds.

According to Giorgi (1986), phenomenological research typically starts with concrete descriptions of lived situations, often first-person accounts, which are set down in everyday language, and avoids abstract intellectual generalisations. These descriptions (Halldórsdóttir 2000) go through a questioning process where the researcher becomes open to the emerging themes. Giorgi (1986) states further that the phenomenological researcher proceeds by reflectively analysing these descriptions, ideographically at first, then by offering a synthesized account; for example, identifying general themes about the essence of the phenomenon. The fundamental aim of the phenomenological researcher is to go beyond surface expressions or explicit meanings to read between the lines so as to access implicit dimensions and intuitions. It is this process of “reading between the lines” that generated uncertainty (Giorgi, 1986).

Finlay (2008) suggests that the types of questions that phenomenological research asks are: How does the lived world present itself to me or to my participant? What does this experience mean? And What is this kind of experience like? Meanings that the research reveals emerge out of the attitude of the researcher and the way the researcher asks the questions. Phenomenological researchers perceive participants in a study as dialogue partners...
and co-researchers; therefore, there is no possibility of contaminating data by full participation of the participants. Both the researcher and the participants collaborate and attempt to make sense of the phenomenon under study. Halldórsdóttir (2000) further adds that the researcher as an expert becomes open to the co-researcher (participant), who is an expert as well in this lived experience. This openness and willingness to hear what the co-researcher is saying can only take place if the researcher puts aside their preconceived ideas about the phenomenon under study. This is consistent with Husserl’s bracketing of the epoché.

**Be-ing in African Thinking**

_The African thought holds that the created beings preserve a bond one with another, an intimate ontological relationship. There is an interaction of being with being... this is more so among rational beings, known as Muntu which includes the living and the dead,_

_Orishas and God._ (Temples, 1955, p. 104).

The above quotation describes the importance of others in African thinking; be they the living, the dead or God. Onyewuenyi (1998) maintains that the ontological relationship among beings enables the African person to know and feel that he is closely connected to other forces which are acting either from above or below him in a hierarchy of forces. This connectedness between the person and the other forces is important in the traditional view of the world and how people are related to it. Finlay (2008) discusses Husserl’s life-world, which is defined as the world that is lived and experienced, – it is a world that appears meaningfully to consciousness; however, it is not an objective world out there, but a humanly relational world. This life-world forms the backdrop for our everyday actions and
interactions, and it focuses on the individual’s lived experience and social world rather than some inner world of introspection. My reason discussing the life-world in this section is to reveal the similarities between the being and African thought, which takes note of the interrelatedness of being with the environment and other beings. The other phenomenological concept that also resonates slightly with the African view of being is Heidegger’s being-in-the-world. What follows is an explanation of how being is embedded in Ubuntu.

Ajei (2007) discusses Ramose’s description of Ubuntu, which comprises two words: Ubu and ntu. Ubu concerns itself with be-ing in general. Ubu is enfolded be-ing before it manifests itself in the concrete form. Ajei further adds that one of the most important characteristics of ubu is oneness. The enfolded be-ing is always orientated towards unfolding, which means that be-ing is striving towards continual concrete manifestations through particular forms and modes of be-ing. Ntu is the process of continual unfolding. Therefore, ubu as a generalised be-ing has the potential of infinite manifestations. Umuntu, which is translated as a human being, is one such manifestation.

According to Ajei (2007), the realm of humans consists of three interdependent levels of existence called the onto-triadic structure of being. The first is the level of the living. This is the level where epistemic discourses occur and where social structures are created and organised. The second is the level of the living dead. In this conception of reality, death implies the discontinuance of the person’s physical being and not the discontinuance of the person’s life. The third level is that of the yet-to-be-born. These are the beings of the future.

Most traditional communities in Africa regard the visible and the invisible dimensions of existence as aspects of a complex wholeness which is inhabited by a multiplicity of beings, some of which share characteristics of both dimensions in African thought. Existing means
standing in a particular relationship with all there is, both visible and invisible; Ramose (Ajei, 2007) refers to this as the wholeness conception of being.

According to Ajei (2007) human beings like all categories of being are part of the generalised be-ing which is called *buntu* in the Bantu language. Being as matter cannot be separated from being as consciousness. Therefore, being is understood as being a wholeness or that which makes everything connected into a whole. This notion of being as oneness leads to the view that each particular existent is merely a speck in a pattern of interaction within the wholeness.

**Reflections**

When I started reading about phenomenology for this chapter, I initially thought it was going to be easy, as there are thousands of written works on this topic; I thought that I would just pick and choose from that vast body of knowledge and would be able to come up with a good solid chapter in a month or so. However, the diversity of work on phenomenology at times made it difficult for me to decide what information to include and what to exclude. The information included in this chapter emerged from what made sense to me as far as phenomenology is concerned; however I should add that there were a lot of backward and forward manoeuvres in an attempt to present work that was not confusing and at the same time adequate for a doctoral study. There were moments when I was so muddled by the plethora of theories and explanations that I felt I needed more time to engage and sit with the information to allow it to make sense to me. The one aspect that stood out is that there is no right or wrong way of conducting phenomenological research as long as one chooses a stance and sticks to it.
Summary

This chapter introduced the concept of phenomenology and examined the phenomenological movement from the preparatory phase of Franz Von Brentano and his colleagues to the French phase of Sartre and colleagues. Edmund Husserl played an important role in phenomenology and his contribution to phenomenology was described. The concept of hermeneutics was also examined in detail. Schleiermacher’s ideas, which have been invaluable in the conceptualisation of modern day hermeneutics, were briefly explored. Of importance is the hermeneutic circle which informs us about the position of the interpreter in relation to the phenomenon during interpretation and how understanding is facilitated by that awareness. Hans-Georg Gadamer also played a very significant role in hermeneutics and this chapter highlighted his insights pertaining to language, historicity and understanding and how one cannot ignore their importance when interpreting the text. Martin Heidegger emphasises the significance of our pre-understandings when interacting with the text in contrast to Husserl’s bracketing notion. The next chapter explores the methodology used in this study.
The World is my Idea—This is a truth which holds good for everything that lives and knows, though man alone can bring it into reflective and abstract unconsciousness. If he really does this, he has attained to philosophical wisdom.

It then becomes clear and certain to him that what he knows is not a sun and an earth, but only an eye that sees the sun, a hand that feels an earth; the world which surrounds him is there only as an idea. i.e., only in relation to something else, the consciousness, which is himself.

Schopenhauer, The World is an Idea, First Book (1818)
Chapter 10
Research Approach

Method is an effort to measure and control from the side of the interpreter; it is the opposite of letting the phenomenon lead. (Palmer, 1969, p. 247)

The previous chapter explored the philosophical underpinnings that inform this research. A detailed discussion of phenomenology was presented including hermeneutic phenomenology which is the stance that I have chosen for this study. This chapter begins with an exposition of the research question, and a justification of hermeneutics in relation to this study is offered. The next section briefly discusses the methodological considerations that should be noted regarding hermeneutic phenomenology research. A brief discussion of the research setting is presented in an attempt to create context for this study. It was noted in the previous chapter that, for understanding to take place, one needs to be aware of one’s pre-understanding of the phenomenon under scrutiny; therefore, as a researcher, I have laid open my pre-suppositions regarding the research question and my reasons for undertaking this study. Discussions on data collection and data analysis will be presented from a hermeneutic point of view. The terms ‘researcher’ and ‘I’ are used interchangeably throughout this study and it should be noted that they have the same meaning in this study unless the intention the use of ‘researcher’ is to generalise.

The Research Question

This study seeks to explore the following: What are the experiences and meanings attached to schizophrenia for patients who are diagnosed with schizophrenia and how do they understand their illness from their cultural point of view? What are the experiences and
meanings attached to schizophrenia for significant family members, and how do they understand the illness from their cultural point of view.

**Methodological Considerations**

Kaffle (2011) states that hermeneutic phenomenology does not prescribe a unanimous methodological set of doing research. Holroyd (2007) argues that there is a lack of available research that offers examples to guide the research process. According to (Smythe, Ironside, Sims, Swenson & Spence, 2008, p. 1391), “as researchers of this methodology, we are never outside our research, never planning ahead with full confidence that we know precisely how it will be; rather we are always already in the midst of the research, confronting the possibilities, making choices, wrestling with the restlessness of possibilities”. Smythe et al. (2008) suggest that this way of being during research is not something that can be learnt from instructions but rather it is part of what one becomes.

Laverty (2003) discusses Polkinghorne’s reluctance to use the word ‘method’ when describing phenomenological and hermeneutic phenomenological studies. According to Polkinghorne, a research methodology is not supposed to be used as a guideline to do research but should be seen as a creative approach to understanding, using whatever approach that will be appropriate in answering the particular research question. Maddison (Laverty, 2003) clarifies the difference between method and methodology and argues that whilst method focuses the researcher on the exact knowledge and procedures, which are rules that guide the research process, methodology on the other hand brings the researcher focus on the use of good judgment and responsible principles.

Whitehead (2004) further states that the methodology that one chooses guides the level of interpretation that will be undertaken during the particular study. Whitehead adds that
the hermeneutic methodological stance ensures that analysis moves beyond description and it cautions researchers adopting this view not to allow interpretation to move beyond the data and out of the hermeneutic circle.

Patterson and Williams (2002, p. 38) argue that selecting a specific research approach depends on the researcher’s perspective. The three issues to be considered when choosing a specific methodological approach are: “…the nature of the questions motivating the research; assumptions about the nature of the phenomenon being studied and the judgment about the relative importance of different research goals in combination with the relative significance of different threats to validity”. Patterson and Williams further maintain that researchers who blindly adopt any methodological prescription without bearing in mind the above-mentioned issues will be committing an error.

According to Patterson and Williams (2002), any methodological decisions that one makes should include the following: a conceptual framework which will inform your pre-understanding; a decision on how data will be presented; an examination of sampling principles that will determine how participants are selected; a decision about data collection methods and data analysis.

Guimond-Plourde (2009) discusses Van Manen’s description of hermeneutic phenomenological methodological criteria. According to Van Manen, the hermeneutic phenomenological research process is made up of four processes. In the first of these, an appeal is made to the researcher to return to the human phenomenon that engages them in everyday life. As the researcher, I have a personal and professional interest in this topic. A full discussion of my pre-understandings will clarify this personal interest; furthermore, as a psychologist, I consult with patients who are diagnosed with schizophrenia and together with
my pre-understandings regarding schizophrenia, I have a personal interest in the phenomenon.

Secondly, Van Manen suggests that the researcher should examine the experience as it is lived rather than as it is conceptualised. This means that theoretical knowledge of the lived experience of the phenomenon should not surpass the lived experience of the phenomenon. Therefore, during interviews, the participants should be allowed to express freely how they experience the phenomenon in their own language without being restricted by structured questionnaires. The interview process and the questions asked should allow the phenomenon to freely reveal itself.

Thirdly, an attempt should be made to identify the themes that characterise the phenomenon under investigation. These themes should endeavour to answer the question “How does it feel to be diagnosed with schizophrenia and what are the meanings attached to this diagnosis?”

Lastly, the researcher should understand the whole on the basis of the part and the part on the basis of the whole. This is consistent with the basic assumption of the hermeneutic circle, which is one of the main concepts in hermeneutics. Van Manen suggests that the researcher should be engaged in both the whole and the part and be aware of the interrelatedness of the two. The researcher’s pre-understanding of the phenomenon is crucial to how one approaches and understands a phenomenon. Below is a discussion of my own pre-understanding in relation to mental illness and psychosis.
Locating Self (Pre-suppositions)

I have always been intrigued by mental illness in general and schizophrenia and psychosis in particular. I believe that that was part of the reason why I chose to study clinical psychology. Therefore, choosing this topic was easy and it addressed the questions that I had always had regarding schizophrenia. I am a Black clinical psychologist working at a community health centre. Some of the patients who consult me have been diagnosed with schizophrenia and some of them seemed to struggle to make sense of what their condition is. Some believe that they are ill because their ancestors are not happy whilst others believe that they have been bewitched.

From the age of six I stayed with my grandmother in a rural area. My grandmother was a traditional Mopedi woman; she believed that her ancestors played a very important role in our lives. When there were challenges or there was something that did not make sense to her, she would offer libations to the ancestors and there was a special place where she would kneel and talk to them. Talking to the ancestors and asking guidance and protection from them gave the family a sense of security.

The Gifted Cousin

Molefe was in his mid-twenties and he had a special gift. Every once in a while he exhibited strange behaviour which was both puzzling and frightening. This behaviour always began when the whole family was sitting around the fire in the evening at my grandmother’s house. Molefe would make an unnerving, deep sound. It sounded as though it was coming from deep inside his ‘being’. He would ask for my cousin who was about 10 months old and he would throw him across the room. The adults knew that they were supposed to sit strategically so that they could catch the child to ensure that he was not harmed. I remember
being very scared in the beginning because I did not understand why Molefe wanted to hurt
the innocent child. Molefe would then start grunting and talking in a weird voice; the voices
would have a different pitch every now and again. I remember my grandmother being very
calm and having conversations with these ‘voices’. I was told that these ‘voices’ were the
ancestors that were communicating with our family through Molefe. My grandmother would
identify the different ancestors based on how they ‘spoke’. The whole episode lasted about 30
minutes. However, for me it felt like hours. After a while, his posture would change and we
knew that he was ‘back’. The same cycle continued every once in a while, especially when he
was intoxicated with alcohol.

My cousin was seen as the ‘gifted one’ and he seemed to be revered by the grown-
ups. At no stage did the family feel that his behaviour was odd, even when he placed the
young child’s life in danger. He was not taken to hospital or the clinic because my
grandmother and the other grown-ups understood his behaviour in the context of our family’s
culture. Therefore, as a child, I too never thought that there was anything wrong with him. As
years went by and I learned about psychosis and schizophrenia, I wondered what would have
happened if my family had sought a medical explanation for Molefe’s behaviour. He would
not have been diagnosed with schizophrenia, but his odd behaviour would perhaps have
warranted some anti-psychotics. Molefe continued with the same behaviour for years and he
was in his late thirties when he died from a lung condition. This story represents my family’s
‘truth’ regarding my cousin’s odd behaviour. We believed that he had a special gift and there
was a sense of quietness and peace that took place after these ‘occurrences’.

After that, my fascination with psychosis and schizophrenia grew. I would grab any
moment that presented itself to have conversations with people who had schizophrenia or any
psychotic mental illness; even before I trained as a clinical psychologist. I found their stories
regarding their perceptions of their conditions very interesting. Some of these individuals who had been diagnosed with a psychotic mental illness felt they knew something that we ‘mere mortals’ did not know. Perhaps it was my own impression that these individuals knew something special that I could never understand. I am very grateful that I had these conversations with them and I feel honoured to have had the opportunity to witness something so personal and something that explained their world to me.

These are the pre-suppositions that I will carry with me throughout this study. This is part of my history and what I understood about psychosis. Even as a clinical psychologist studying towards my PhD, these prior understandings still colour my view and they affect how I engage with patients who are diagnosed with schizophrenia. I understand the medical model explanation of schizophrenia and the DSM-V criteria for diagnosing schizophrenia. I know that anti-psychotics can alleviate the symptoms of people diagnosed with schizophrenia. However, I also know that from a cultural point of view, there are people, like my grandmother, who have a different explanation and understanding of schizophrenia.

Mueller-Vollmer (1986) describes Bultman’s view on the importance of presuppositions: the interpreter needs to be open about their pre-suppositions, and he stresses that interpreters should approach the text from a certain point of view and that they have ideas concerning the text. However, Bultman warns interpreters against taking their pre-understandings as definitive understanding, as this falsifies the historical picture of the text. Heidegger is of the opinion that we understand and accept a given text because we bring into play a preliminary intention regarding the situation, an already established way of seeing (Palmer, 1989). The next section creates the context of the study by describing the research setting.
Research setting

The research took place at a Community Health Centre in Soshanguve. Soshanguve is a historically Black township situated about 30km north of Pretoria, Gauteng, South Africa. According to the 2011 census, Soshanguve has a total population of 403,162; 99.97% of the population are Blacks, 0.28% are Coloured, and Whites constitute 0.07% of the population. The most widely spoken language in Soshanguve is SePedi followed by SeTswana. Over the past few years, the township has expanded with a substantial amount of housing being informal houses made of corrugated iron sheets. However, there are formal houses ranging from big extravagant houses to four-roomed brick houses. The township is serviced by a tertiary hospital which has specialised medical personnel. There are two district hospitals situated less than 30km from Soshanguve and several community health care centres that offer health services. All community health care centres have a mental health department and there is a psychiatrist who visits the clinic at least once a week. There are other smaller clinics that refer patients with mental health problems to the community health care centres.

Sampling

A purposive sampling method was used to select participants for this study. Laverty (2003) states that selection of participants in hermeneutic studies differs from traditional positivist research methodologies where the sample has to meet statistical requirements. Cohen, Kahn and Steeves (2000) argue that random sampling is not consistent with the hermeneutic, which is a method used mostly by researchers who seek to attain a sample that meets statistical requirements. Patterson and Williams (2002) maintain that the concept of sampling has different connotations depending on one’s frame of reference; representativeness could be a matter of addressing the statistical requirements of a study or it could be conceived as how well or how richly and thoroughly the findings represent the
phenomenon that is being studied. According to Patterson and Williams, specificity in the depth of understanding is at times preferred to generalisability. Therefore, in order to enable the phenomenon to reveal itself, a sampling method that is consistent with hermeneutics is sought.

Van Manen (1997) adds that in hermeneutics, the aim of participant selection is to select those participants who have lived experience of the phenomenon that is studied; they should be keen to talk about their experiences and they should be diverse enough to offer rich and unique stories of that particular experience. Englander (2012) perceives sampling as one of the most important processes in hermeneutic research because it forms the most crucial part of data collection. One of the fundamental questions that researchers should ask themselves when deciding who to choose for the study is “Do you have the experience that I am looking for?” (Englander, 2012, p. 19). The sample size does not have to be as large as in quantitative studies, as the aim of hermeneutic phenomenology is not to generalise the outcomes of the study. Englander mentions Giorgi’s opinion regarding the appropriate sample size in phenomenological studies, which according to Giorgi is at least three participants. Creswell (2007) considers a sample size of between three and ten to be adequate for phenomenological studies.

For this study I have decided to interview six participants in total, three of whom are patients who have been diagnosed with schizophrenia and are receiving medication from Soshanguve Community Health Care Centre; the other three are their significant family members. These participants have to meet the selection criteria described below.
Selection criteria

Inclusion criteria for patients

- Participants should have been diagnosed by the psychiatrist and meet the DSM-1V TR criteria for schizophrenia. They should be receiving medication for the condition.
- Participants should be Black and Setswana or Sepedi speaking.
- Participants should be able to have a logical conversation and be able to express their experiences.
- Participants should be able to provide informed consent.
- Participants should be 18 years or above.

Inclusion criteria for family members

- The family member should play a significant and supportive role in the patient’s life and should be involved in their medical treatment.
- They should be 18 years or older.
- They should be able to provide informed consent.
- They should be able to give an account of themselves.

Exclusion criteria for patients

- Patients who do not meet the DSM-1V TR criteria for schizophrenia
- Those who, due to their illness, struggle to express themselves.
- Patients who cannot give informed consent due to their inability to understand what the study is about.
- Patients who are younger than 18 years.
Exclusion criteria for family members

- Those family members who are not actively involved in the treatment of the patient.
- Family members who are below 18 years of age.
- Family members who are not able to express their feelings and emotions and cannot give an account of themselves.
- Family members who are not able to give consent.

The next section discusses the recruitment process and challenges that were encountered during the recruitment of participants.

Recruitment Process

The mental health nurse at Soshanguve Community Health Care Centre played a very important role in the identification and recruiting of appropriate patients. The inclusion and the exclusion criteria were explained to her and it was agreed that it would be easier if she identified the patients and their family members. The mental health department does not have a permanent psychiatric nurse; every year there is a new nurse and it takes the new nurse about four months to get to know the patients and the routine in the department. Therefore, assisting in the identification of appropriate patients for this study was not a priority for the nurse. I understood her reluctance because their department is busy and most of the time they do not have time to perform their daily administrative duties. The other challenge in finding appropriate participants during the recruitment process was the reluctance of some patients to take part in the research process. The importance of language and how language and understanding are interrelated was discussed with the mental health nurse. We decided that
her role would be to identify the appropriate participants and that I would introduce the study to them.

**Data collection (Entering the Dialogue)**

Ajjawi and Higgs (2007) point out that an interview serves specific roles in hermeneutic phenomenology studies: it is used to explore and to gather stories of lived experiences; secondly, it facilitates the development of a conversational relationship between the researcher and the participant. Therefore, establishing rapport before the interviews played a crucial role. Laverty (2003) suggests that the interviews process in hermeneutic phenomenological studies should occur in an environment of trust and safety. Therefore, the interviews in this study took place in my office, which is quiet and private. The interviews took about an hour to an hour and a half. The patients and their significant family members were interviewed separately. The conversation that took place between the researcher and the participants was audio-taped with written consent from the participants. Some notes were also made to note nuances that were not captured by the audio-tape, like body language and other comments that were made outside the audio-tape conversation and were deemed relevant and important to the study.

Smythe et al. (2008) argue that although structured interviews with a pre-organised plan for the process are not consistent with hermeneutic studies, one cannot approach the interview with no sense of why one is in dialogue with the participants. However, the researcher is encouraged to have an openness that will enable their whole being to be part of the conversation. To achieve the stance of openness which is required in hermeneutics, open-ended conversations were held with mental health care users and their significant family members. The following question was used to guide the research: What are your experiences
and viewpoints regarding schizophrenia from your cultural point of view? Probing questions emerged from the answers that the participants gave. The question was used as a guideline only and subsequent questions changed based on the information that arose from the conversation.

Management of Data

The recorded conversations were played and transcribed by the researcher soon after the interview. This took place in a private space where there was no risk of anyone listening to the conversation. These recorded conversations and transcribes were kept in a computer file that was password protected. The recordings were deleted as soon as all the information was obtained from them. The identity of the participants was protected by using pseudonyms throughout the research.

Data Analysis

According to Gadamer (1975), hermeneutics is understood as a process in which there is co-creation of experiences between the researcher and the participant; this results in meaning production which takes place through a circle of readings, reflective writings and interpretations. In hermeneutic analysis, the text which is representing the individual participant is read so that an understanding of data is obtained; this bigger understanding is utilised for an in-depth examination of the different parts (Patterson & Williams, 2002). This is consistent with the hermeneutic circle where parts and wholes are explored for clearer understanding.

According to Patterson and William (2002), hermeneutic analysis does not take place after data has been collected but begins during data collection. Themes that emerge from the
first interaction with the participants were used to guide the researcher in what questions to ask in the subsequent interviews. The next section discusses the steps that were followed in data analysis.

**Steps in Data Analysis**

As discussed earlier, there are no specific rules or off-the-shelf recipes that guide the research process in hermeneutic phenomenological studies; the most important factor that one has to keep in mind is to stay true to the basic assumptions of one’s theoretical stance. The steps that are described below only served as a guide during the data analysis process. It should be noted that there is no distinction between analysis and interpretation in hermeneutic phenomenological studies; both processes occur at the same time (Guimond-Plourde, 2009).

Terre Blanche and Kelly (1999) argue that there are many analytic traditions that come under the umbrella of interpretive analysis. Thematic analysis is used to interpret data. Van Manen describes thematic understanding as a free act of seeing meaning (Smythe et al., 2008). Furthermore, Van Manen adds that themes are not necessarily things that are said repeatedly in the text; rather they are an understanding that there is something significant that the reader is pointed towards. The steps of analysis as discussed by TerreBlanche and Kelly (1999) that were followed during analysis are discussed below.

**Step 1: Familiarization and immersion**

Data analysis is not just a mindless technical exercise, but involves the development of ideas and theories about the phenomenon being studied. Preliminary understanding of the meaning of data began during this process. This process enabled the researcher to familiarise herself with the data. The researcher listened to the tapes and read the transcribed interviews.
The audio-tape was played over and over. The text was also read through many times over to extract meaning; and notes, diagrams and drawings were made.

Step 2: Inducing themes

Induction means to infer general rules or classes from specific instances. The researcher looked at the material and worked out what the organising principles were that naturally underscored the material. The language of the participants was used rather than abstract theoretical language to label categories. Processes, functions, tensions and contradictions were examined.

Step 3: Coding

Coding is undertaken during the activity of developing themes. Using the same highlighter for words with similar meanings, the researcher marked different sections that were relevant to one or more themes. The text was then broken down into meaningful pieces and labelled.

Step 4: Elaboration

Themes were explored more closely. The purpose is to capture the nuances of meaning not captured by coding. Coding and elaboration were carried out until no further significant insights emerged.

Step 5: Interpretation and checking

This is the final step where the phenomenon that is being studied is put together. Thematic analysis involves identifying the common themes in the information and using excerpts from the information to substantiate those themes. The researcher works through the
interpretation to look for contradictions. The next section discusses the trustworthiness of hermeneutic phenomenological studies.

**Translation Issues**

The researcher in this study conducted the interviews in the participants’ native language, which is not English. One of the challenges that face qualitative researchers, according to Fersch (2013), are issues relating to translation of data from one language to the other. Fersch argues that language plays an important role during data analysis, and there is a gap within the qualitative research literature in terms of language barriers and translation dilemmas. From a phenomenological hermeneutic point of view, language plays a pivotal role in understanding and interpretation. According to Gadamer (Fersch 2013, p. 90), translating the text from a foreign language poses an “extreme case of hermeneutic difficulty.” If translators are used, they form part of the co-creators of meaning of the text; hence, Fersch (2013) insists that it should be noted in the research design if translators were used.

In this study, the researcher and the participants share the same language and culture; therefore, translators were not used. The interviews were analysed and interpreted in the language of the participants. It was during the writing up of the interpretations that the English language was used. Fersch (2013) warns against what is called dual researcher/translator role where the researcher is fluent in the participants’ language which is not the researcher’s native language. The challenge in this instance becomes interpretation in the language that is not native to the researcher. Cheng (2010) on the other hand discusses Shklarov’s opinion regarding bilingual researchers who speak the participants’ language and are fluent in English as well. According to Shklarov, bilingual researchers play an invaluable
role as they are able to see parallel cultural meanings or realities; they are able to identify and understand the nuances of speech that might be lost in translation.

**Trustworthiness**

One of the most important aspects of any research in general is its validity and reliability; hermeneutic phenomenological studies are no different. Lincoln and Guba (Kaffle, 2011) identified four standards, which according to them represent “trustworthiness” as a replacement for validity and reliability concepts which are appropriate for quantitative studies; they have decided instead to use the following concepts: credibility, transferability, dependability and conformity. However, Van Manen maintains that the terms do not fit appropriately with hermeneutic phenomenological studies (Kaffle, 2011).

According to Sandelowski and Barroso (2002), researchers within the social sciences disciplines have been trying to define what a good, valid and trustworthy qualitative study entails and they have also attempted to categorise and develop techniques which will ensure good studies. After all that effort, no consensus has been reached regarding quality criteria for qualitative studies. Sandelowski (1993) examines Mishler’s interrogation of the concept of trustworthiness of qualitative studies. According to Mishler, most researchers base their trustworthiness claim of their studies on the premise that they can show that their participants responded consistently over time regarding an experience. This claim is based on the assumption that reality is external, corroboratory and can be repeated; however, in interpretive studies reality is multiple. Laverty (2003) suggests that quality claims in phenomenological studies be discussed as issues of rigour.
Rigour

Conducting hermeneutic research does not mean that ‘anything goes,’ therefore issues relating to the study’s credibility need to be explored. Sandelowski (1993) argues that rigour in qualitative research is a contentious debate that will continue to misdirect and entice. According to Sandelowski, qualitative researchers succumb to what she calls the “illusion of technique” in an attempt to produce techniques to be used in ensuring rigour. The inflexibility, harshness and rigidity that is applied when discussing rigour in qualitative work may endanger the artfulness, the sensitivity to meaning and context which are the hallmarks of qualitative researches (Sandelowski, 1993). Morse, Barrett, Mayan, Olson and Spier (2002) maintain that attention has been given to reliability and validity in all research methods because without rigour, any type of research is as good as fiction; it is worthless. Laverty (2003) is of the opinion that discussing rigour in interpretive studies can be confusing, as there is no universal set of criteria that can be used to assess it and the language used also creates challenges. Some of the challenges in describing rigour in qualitative studies is that due to the ‘lack’ of certainty of hard numbers which computer systems appear to offer to quantitative studies, there seems to be a crisis in terms of what qualitative researchers perceive as rigour (Morse et al., 2002). This has resulted in what Kaffle (2011) views as opposing opinions regarding the quality claims of hermeneutic studies.

According to Ajjawi and Higgs (2007), rigour and credibility in qualitative research are mutually inclusive; this means that for a study to be seen as credible, the research process needs to be rigorous. The authors claim that a rigorous use of a systematic method of data collection and analysis together with transparency in documenting these is one of the requirements for ensuring the quality of a research study. According to Beck (Laverty, 2003,
p.23), credibility in phenomenological studies depends on how “vivid and faithful the description is to the experience lived”. Beck adds that others will see the text as the statement of the experience itself. Lincoln and Guba (Ajjawi & Higgs, 2007) also add that one needs to be truthful and consistent towards one’s theoretical assumptions and there should be congruence between the research question and the research approach.

**Role of the Researcher in Ensuring Rigour**

The researcher plays a very important role in hermeneutic phenomenology studies and, according to Morse et al. (2002, p. 10), “research is only as good as the investigator”. Whitehead (2004) notes the importance of the researcher’s influence in hermeneutic phenomenological studies. Whitehead discusses Heidegger’s examination of the importance of the researcher’s presuppositions and how these affect the interpretation of texts. Heidegger believes that our history cannot be disregarded, and for textual interpretation to be sound, the researcher has to reveal their pre-understanding of the phenomenon that is under study. Husserl on the other hand is of the opinion that the reader of the text should suspend or bracket their pre-understanding of the phenomenon. Whitehead (2004) indicates that the researcher’s credibility is crucial in ensuring rigour in qualitative studies. Whitehead further insists on the researcher’s self-awareness and revealing one’s experiences and prejudices.

It is mentioned in this section that the researcher needs to have certain characteristics that will enable the connection between the participants and the researcher, thereby enabling the conversation to flow freely. As a practising clinical psychologist, I have the necessary skills needed to build rapport. The process of sampling and the number of participants are appropriate for this study; the data collection methods fit with the philosophical stance of this research. The researcher’s presuppositions are invaluable in this research; I have declared my
interest in this study and my own presuppositions regarding the study have been clearly described. When discussing the participants’ stories I will mention my own thoughts regarding the phenomenon that is being discussed. There will be a fusion of horizons; that is, the participants’ horizon and my horizon will meet and a back-and-forward movement between the two will take place. The interpretation of the data will be done using hermeneutic phenomenological concepts; this is a necessary step in maintaining rigour as I will be staying true to the methodology that I have chosen. Therefore, this study meets the rigour principles of hermeneutic phenomenological studies.

**Member Validation and Rigour**

Some researchers use member validation, which is a technique used to check the validity of the interpretations by requesting the participants to read through the interpreted data and state if that represents their experience of the phenomenon that was studied. Sandelowski (1993) discourages using member checks for the following reasons: participants may want to see their experiences described in concrete terms and they may feel that the interpreted data does not represent their views of the phenomenon. It should be noted that the interpretations will be conceptualised thematically. For example, the participant mentions that since he was diagnosed with schizophrenia some of his friends have not been visiting him as regularly as before, and the researcher describes this thematically as disconnection. The participant may feel that the theme ‘feeling disconnected’ does not describe his experience. Secondly, Sandelowski indicates that stories change over time and experiences may change from the time the conversation with the participant took place to the time interpretations are ready for perusal. They may not have the same emotions they felt during the interview; this does not make their feelings invalid. Therefore, member validation cannot be used to ensure
rigor. For this study, I also decided not to use member checks for the same reasons as stipulated by Sandelowski.

Giorgi (2008) adds that when researchers verify their phenomenological findings through member checks, they assume that the participant is the expert of his experience, therefore asking him to validate the findings is a confirmation of the truthfulness of the findings. Giorgi argues that the participants do have the knowledge of the experience but do not know what the meaning of the experience is.

To ensure rigour in this study, the methodology that was chosen is capable of answering the research question. To be able to explore the experiences and the meanings of patients diagnosed with schizophrenia, a methodology is needed that will allow them to engage freely with the researcher and tell their stories in such a way that the phenomenon that is under study reveals itself. The relationship between the participants and the researcher is very important and the researcher set out to build the rapport with the patient before the start of the formal interview process.

Van Manen discusses four steps in the analysis process to be considered in order to ensure rigour in hermeneutic studies (Kaffle, 2011, p, 196):

- **Orientation**: This is the involvement of the researcher in the world of the research participants and their stories. The researcher listened attentively to the participants’ stories. The participants were seen as the expert and the researcher only asked probing questions to get more information or to clarify something.

- **Strength**: This refers to the convincing capacity of the text to represent the core intention of the understanding of the inherent meanings as expressed by the research
participants through their stories. The researcher used excerpts or anecdotes from the participants’ stories to analyse the data.

- Richness is intended to serve the aesthetic quality of the text that narrates the meanings as perceived by the participants. The words used by the participants were used so that the tone of the story stayed true to the participants’ conversation.

- Depth is the ability of the research text to penetrate into and express the best of the intentions of the participants.

Sandelowski (1993) laments the need on the part of some researchers to defend their research projects to the extent that they are preoccupied with techniques and building fortifications against attacks by positivist researchers. This suffocates the stories, “meaningful portraits and landscapes of human experience that constitute the best rigor in qualitative work” (Sandelowski, 1993, p.1). Sandelowski cautions that the spirit of qualitative work can either be preserved or killed depending on whether we choose to be true to the philosophical underpinning of our studies or adopt rules that have the potential to threaten the nature of our studies.

**Writing up Hermeneutic Phenomenological Research**

Researchers engaging in hermeneutic phenomenological studies should be mindful of the role that writing serves in research, and writing should not be considered as the final or last step in the research process (Van Manen, 1997). Kaffle (2011) highlights the importance of making use of a specific writing style when discussing data and argues that everyday language cannot do justice when expressing the participants’ experiences. According to Kaffle (2011), in order to make quality assertions regarding one’s study, it is imperative that
one pay attention to rhetoric. Kaffle defines rhetoric as “the writing or reporting style of the research work” (p. 196).

Van Manen (1997) appeals to researchers to pay attention to the nuances and undertones of language and to the way that language makes it possible for things to reveal themselves. Van Manen (2006) further adds that qualitative writing requires that, as researchers, we have to be attentive to the other voices and we need to stay in contact with the others’ words; we should allow ourselves to be stirred and guided by the their words. The writer uses words to reveal what is hidden. On the other hand, Van Manen (2006, p. 719) indicates that a word also has the ability to “annihilate or kill whatever it touches”. This means that one needs to be aware of how one writes up the participants’ stories. Inasmuch as using words to discuss the participants’ experiences of their illness has the potential to reveal or uncover that which is hidden and out of reach; it will bring nearness to what is elusive; how we write our research can destroy what we aim to bring to the open.

Through writing, the writer enters the dark and hidden space of the text hoping that what was previously not seen can be seen and what was unheard can be heard (Van Manen, 2006). Therefore, the words that the participants use to describe their experiences are very important and they should be noted. In order to do justice to the stories that the participants will be telling about their illness, anecdotes should be used.

Van Manen (1997) discusses the uses of anecdotes, which according to him are the most important tools in phenomenological writing. An anecdote is defined by Webster as “a short narrative of an interesting, amusing or biographical incident” (Van Manen, 1997, p.116). Van Manen further explains that anecdotes usually begin as part of an oral tradition and he quotes Samuel Johnson who describes an anecdote as “a minute passage of private
Van Manen is of the opinion that the use of anecdotes in phenomenological writing should not be seen as merely ‘literary embellishment’, but as stories that allow the human sciences text to attain a narrative quality that is usually characteristic of a story. Using anecdotes allows the themes that emerge from the participants’ stories to be grounded in the data.

Derrida’s notion of what characterises good and bad writing is described by Van Manen (2006). According to Derrida, the distinction between good and bad writing is dependent on one’s reliance on method. Derrida is of the opinion that following set techniques and steps, from a phenomenological point of view, is bad writing. Derrida subscribes to Heidegger’s view that genuine phenomenological method requires that we create our own path instead of following a predetermined path. Therefore, when writing up a phenomenological study, using the usual five-chapter research studies format with predetermined headings will not be a good fit. The next section discusses ethical issues that were taken into consideration during this study.

**Ethical Considerations**

**Ethics Review Boards**

Ethical approval for this study was sought from the Science and Ethics Research Council of the University of Limpopo, Medunsa Campus. The final approval was granted by the Medunsa Research Ethics Committee in September 2013. As the study was conducted in the clinic which is under the jurisdiction of the Department of Health, their ethics approval was also sought and was granted in February 2014. See appendix 3 for the ethical approval certificate.
Informed consent

The participants were given a full explanation of what the research entailed and they were made aware that they were free to withdraw from the study if they so wished. The consent form, which is included in appendix 1 and 1a, describes the study and its aims and objectives. The consent form is in both English and Setswana, which is the most widely spoken and understood language in Soshanguve.

Non-Maleficence

The principle of non-maleficence requires the researcher to make sure that no harm is inflicted on the participants by monitoring their responses. The researcher was sensitive towards the feelings of the participants and dispelled any feelings of being labelled or stigmatised. Throughout the interviews, the emotions of participants were monitored in order to ensure that they were not harmed as they went through the process of revisiting issues that might be painful and traumatic for them.

Beneficence

The principle of beneficence requires the researcher to design the research such that it will be of benefit, if not directly to the research participants, then more broadly to other researchers or to the society at large. Therefore, this study hopes to add to the body of knowledge relevant to schizophrenia and Black South African culture.
Confidentiality

To protect the participants’ confidentiality, pseudonyms were used throughout the study. Any information that might have given away the identity of the participants was changed.

Summary

The basic assumption of hermeneutic phenomenology studies is that there are no prescribed steps to be employed when undertaking research. The above steps were chosen by the researcher as they seemed appropriate for hermeneutic phenomenology studies and they were used only as a guideline for this study. A description of my pre-suppositions created context in terms of what it is that I bring to this study; this knowledge will be discussed together with the participants’ stories in a later chapter. The next chapter introduces participants of this study.
There is no story that is not true...

The world has no end, and what is good among one people is an abomination with others.

Chinua Achebe, Things Fall Apart (1958)
Chapter 11

The story tellers

This chapter introduces the six story tellers with whom I had conversations with regarding their perception, understanding and the meanings that they attach to schizophrenia. The aim of this chapter is to create context and background to the stories and the study.

According to Wolf (Palmer, 1969) argues that the interpreter should have the aptitude to enter into the mental world of the other person and having the factual knowledge of the author is paramount in ensuring that textual interpretation becomes appropriate. The following is a description of the story tellers and an explication of the family dynamics that, from a systems perspective, highlights the relationships in these families which could possibly contribute to the emergence of schizophrenia. The story tellers (participants) come from three different families; therefore, their description will be categorised according to their families. Sindi and Thembi belong to the first family; James and Mary to the second family and lastly, Leseka and Pumla belong to the third family.

First family

Sindi

_I was not able to face reality. I would strangle the child, wanting to kill her. I was close to killing her. That is, when I remember, eh...I was going to... They then took me, I wasn’t sleeping. My problem was that I was not sleeping. It seems like my mind was working overtime. And it was busy with negative things, things that are not reality._

Sindi is a 41 year old woman who has been diagnosed with schizophrenia since 2003. She is taking her anti-psychotic medication from the clinic in Soshanguve. Sindi is currently staying with her partner and they have been together since 2008. Sindi was asked by the
psychiatric nurse to take part in the research after a brief explanation of the type and reason of the study. I got her number from the nurse and phoned her a week after the initial contact with the nurse. I explained to her what the study was about and she agreed to be part of the study. I told her that she will get a full explanation of the research when we meet and if she had any questions she was encouraged to note them down for discussion when we meet. We agreed to meet in two weeks’ time.

Sindi came 45 minutes earlier for the appointment. Initially she was a bit uncomfortable, however, it did not take long for rapport to develop. The appointment took place in summer and Sindi was dressed in a bright skirt and print top. She was well kempt and she made eye contact during the interview. We discussed the research and the fact that our conversation was going to be audio-taped. She was given an option of reading the information and consent in English or SeTswana and she requested the English version. Sindi spoke English occasionally during our conversation and the other times she conversed in SeTswana. As soon as the audio-tape was switched on, she started telling me about how her illness started before I asked any question.

Sindi has an LLB degree and has just written her law board exams. She has so far passed all subjects except for one which she is still waiting for the results. She was a candidate attorney in Bloemfontein and she is passionate about her work and proud that she is almost done with her Law studies. She is currently not employed; the candidate attorney placement was on a contract basis and it expired after a year. She is getting a Disability Grant of R1 200, 00. Her younger sister assists financially if there is a need. She is the second of five and she stated that all her siblings has degrees except for the last born who got an academic exclusion from a college because he was not working hard enough. Sindi was born and raised in an urban township where there is a mixture of cultures, languages and beliefs.
Sindi describes her illness as being negative and she has major issues regarding disclosing her illness to others. Even though Sindi stays with her long-term partner, she chose her mother as the family member to be interviewed because she feels that her partner does not really know how her illness started. She gave me her mother’s contact number and promised to brief her mother about the study and that she should expect my call.

**Thembi**

*I just want to live my life the way I want; I don’t want to always be suspicious of other people. I think we have to live our lives like birds; they carry on with life without any worries. You see, they don’t work but they have food; they find food anywhere and they don’t go hungry. They just hustle to stay alive… (Laughing). We need to live our lives like that; it is a good life.*

Thembi is a 63 year old woman whose daughter, Sindi has been diagnosed with schizophrenia. I phoned Thembi to make an appointment and she was very willing to have a conversation with me regarding her views about schizophrenia and her daughter’s illness. Thembi sells fruit and vegetables at a taxi rank and we agreed that I will come and collect her from her work as it will easier for both of us. The interview took place at her house which is about 15 kilometres from her workplace. Thembi’s house is big and modern. She says that compared to their neighbours, they have always been affluent. She was dressed in work garb; an apron over jeans and a T-shirt. Thembi is getting a state pension of R1200, 00. Thembi left school in Grade 5.

Thembi was raised by her paternal aunt because her mother was admitted in a mental institution from 1952 till 1987 when she passed away. According to her, Sindi’s illness is due to her keeping things bottled up and the other stressors that she experienced. She also
believes that her mother’s illness was possibly due to the fact that his father didn’t give enough care attention to her mother. She is a spiritual person who doesn’t trust traditional healers; she thinks they are all charlatans; however, Thembi believes that ancestors do exist and that they are sometimes responsible for what happens to the living. When Sindi fell ill and she was told by the medical doctors that Sindi has a mental illness, she appealed to her ancestors to spare her family and leave her kids alone. She feels that they have listened to her and that her family is safe now.

The conversation flowed easily and Thembi was such an amazing narrator; she gave context to whatever question was asked and that gave so much depth in her explanation of things. It is challenging and hurting for her to have a child with a mental illness; however, her hope that things will be okay makes it easier for her to carry on. This family does not talk much; she says that she talks about things that bothers her but her children are secretive. Even though she claims to be open to others about her feelings, like her daughter Sindi and the other daughters, she does not talk about Sindi’s illness. The whole family seems to pretend that she is okay and that is possible their defence mechanism. However, the silence regarding what is there makes it hard for Sindi to garner the support of her family. Disclosing and talking about her illness is a big issue for Sindi. Thembi grew up in an urban township. The next page is an illustration of Sindi’s family’s genogram.
Figure 3: Genogram for Sindi
Family dynamics

This family has experienced a psychotic mental illness before. Sindi’s grandmother was admitted to a psychiatric hospital for years until her death. Therefore, for Thembi this is a reminder of something that happened to her family years ago. Sindi seems to have been the most financially viable and responsible before her illness. Even though Sindi’s siblings are all educated, she is the one with highest qualifications. From the discussion with the mother, it seems Sindi’s father is not playing an active role in the family. Her mother is the one who is out there to try and make the family survive. Just before Sindi fell ill, there were financial problems at home. Their house had to be auctioned by the bank because the loan that her father could not pay the loan that he took out.

The dynamics that took place in this family will be explored from a family theory perspective. Lidz and co-workers (Robbins, 1993) argue that schizophrenia in the family occurs when there is a distortion in the role relationships between parents; the mothers are dominant and the fathers are passive. According to Lidz, children raised in such environments develop a distorted view of their identity and they have unrealistic ideas about the outside world.

The conversations I had with both Sindi and her mother gave the impression that the father was “absent”. Thembi made all the decisions about Sindi’s treatment and the father had no input in how the family was going to manage the illness. Thembi felt that the survival of her family was in her hands. After they lost their house, she says that she decided to get a piece of land so that her children can have some place to go to should things not work out. The whole conversation had statements like: “I did this”; “I decided to do that”. Nowhere did she consult with her husband or did she say that Sindi’s dad said that. When asked about how the family is coping with Sindi’s illness, she mentioned her three children only; her first born son was not mentioned at all. The husband and the older son seemed not to be part of the family.
The timing of the first psychotic symptoms seems to have some significance in the family. The father let the family down by making them lose their house. This is the family that was highly regarded by the neighbours because their socio-economic status was higher than those around them. The level of strife at home escalated during that time. They had nowhere else to go and it was at that time that Sindi started having her first psychotic break. The ground work was laid by the dynamics between the dominant mother and the passive father. She has been the sensitive one of all the children. Thembi says that her daughter that comes after Sindi told her that Sindi’s temperament as a child was perhaps a sign that things were not well with her. Her symptomatic behaviour could have been a way taking the focus away from the huge financial dilemma at home.

Understanding these dynamics when dealing with families where one member has severe symptomatic behaviour is useful. Steinglass (1987) is of the opinion that correcting pathology in one part of the system (family) leads to temporary alleviation of symptoms. Therefore, from a psychotherapeutic point of view, one would challenge the dynamics between the parents. This will relieve the child of the need to take responsibility of maintain the integrity of the family system through symptomatic behaviour.

It should be noted that systems are those entities that can maintain some organisation in the face of change from within and without (Rapoport, 1968). Sindi’s family system was threatened by the great financial upheaval that befell the family due to her father’s mistake. The aim of discussing the family dynamics and their relationship to the beginning and maintenance of psychopathology is present a possible hypothesis from a systems theory point of view. This is not meant to be a judgment at the family but to reveal that people are part of the family system and what takes place in the system has an effect on parts of the system. Bateson (1971) argues that systems contain feedback structures therefore they have the ability to process information and act appropriately for the survival of the system.
Second family

James

Yes. People talk…they talk a lot. They say I am crazy; it hurts a lot when people say that about me. They are the ones that make me get all messed up; especially people in my home town.

James is a 55 year old man who have been diagnosed with schizophrenia since 1984. My first encounter with James was at the mental health clinic where they came to fetch his medications. I was discussing the challenges of getting suitable participants for this study when he walked in with his sister Mary. I decided to explain to them about the study and they both seemed keen to take part. They both agreed to see me in my office at the clinic in two weeks’ time. James was well kempt and there was an air of calmness about him. The conversation was comfortable and flowing.

James is unemployed and is getting a disability grant of R1 200.00 from the government. He is currently staying with her sister Mary. Mary’s house has two bedrooms and a one roomed out building where James sleeps. Of all his siblings, James is the only one that did not attend formal school. James grew up on a farm where his parents worked and he also worked as a farm labourer from an early age. He came to the city when he was older to seek better opportunities and he worked at what seemed like a fertiliser manufacturing factory. James grew up in a rural area where the culture and the language spoken was homogenous.

James’ mother passed away in 2000. She was the one who was taking care of him since his illness began. His father is still alive and they have a mercurial relationship. The tension between him and his father is one of the reasons he has to stay with his sister. James wants his father to understand his illness and he wants the bad blood between them to be sorted out. However, his father wants nothing to do with him. James is the second of five.
James was hospitalised three times for schizophrenia. The last hospitalisation was in 2005 after he bit his father’s ear off. He is stable on anti-psychotic medications. He says that when he is ill he hears voices and he has not heard the voices in a few years. James is not so dependent on his sister like before; he is able to go to the post office and perform transactions on his own. James used to smoke marijuana, especially in the early stages of his illness.

James never married nor does he have an intimate partner. He says if he was not ill, he would still be working and he would have been married. James attends church but is not a regular church goer. When his illness started, his mother sought help from the traditional healers. Since taking medication from the hospital, he has never consulted any traditional healer for schizophrenia. He thinks that his illness was caused by the noise at work.

Mary

*I was so hurt at the way the police forced him out of the van; he was so uncontrollable and angry. I was scared (crying) that they were going to physically hurt him. I asked them to leave him and told them that I will get him out of the van (sobbing).*

Mary is a 52 year old woman who is the sole carer for her brother James. She started caring for James after their mother passed away in 2000. Mary has two children, a son who is 24 years old and a daughter of 16. Her son is engaged to get married soon and her daughter is in Grade 10. Mary attended school till Grade 9. She says she left school in order to work and help her younger siblings further their education. Mary is not married neither does she have a partner. She says she could not pursue intimate relationships because she had to focus on caring for her brother.

Mary is not employed and she and her son provides for her. She was forced to stop working as caring for her brother was initially a full time job. She is very emotional as she recounts the challenges that she went through after her mother died. As the older daughter, she feels it is her responsibility to
take over her mother’s role of caring for everyone. Mary received no support from her siblings and father and she found herself sacrificing a lot. She is ambivalent about her role as a carer; she wants to care but she also does not want to care because the burden of caring is too much at times.

Mary is a church goer and attends women’s meetings at church regularly. Being part of the church community helped her cope with the burden of caring. She is also of the opinion that traditional are not helpful in treating schizophrenia. Mary reports that she is being getting headaches recently and she thinks that perhaps the stress of caring for her brother and other issues relating to the other siblings that is affecting her health. Mary’s father is elderly and frail and she feels torn between her own nuclear family and her family of origin. She has a younger sister who has depression. Her depression was so severe and debilitating that she had to be admitted in hospital for 3 months. The last born has a physical disability and she has to sort out his disability grant. The eldest brother does not care much about what is happening. The other brother is married and his focus is on his wife and children. Like James, Mary thinks that her brother’s illness was caused by the noise from the factory that he worked in at the time of the first symptoms of schizophrenia. The following is James’ genogram:
Figure 4: Genogram for James
Family dynamics

James was raised in a family where both parents were farm labourers; the parents worked hard to provide for their children. His mother, who was his primary care giver died suddenly in 2000. James’ mother was also the breadwinner as his father has stopped working. In this family, it seems each child had specific roles that they were supposed to fulfil. Mary’s role was to be the mother of the other siblings. She left school before completing her high school studies because she felt that her parents were not able to support her siblings with their studies; she sacrificed her education for her siblings because it was her role to make sure that they get a better education. The first born brother abdicated his role as an older brother. Mary says that he does not act responsibly like older brothers are supposed to. Therefore, there was no one who was responsible. The other brother is married and he is focusing solely on his new family and has disengaged himself from his family of origin. James is the only sibling who did not attend formal schooling; he worked in the farm whilst others went to school. He was the one who also helped to take care of the family financially. During his early adulthood James went to the city to look for work that paid more than farm work. He found work as a general help at a manufacturing company. His first symptoms of schizophrenia began at his place of work. He went back home and his symptoms subsided. After his mother’s death in 2000 he had a severe psychotic break and was admitted in a psychiatric hospital for six months.

One of the fundamental processes that are manifested by families is centralisation (Ackerman, 1985). This means that changes in the dominant part of the family produce large changes in other parts of the family. It can be assumed that the death of his mother was a major change for James. The family was no longer able to regulate itself or maintain equilibrium (Ackerman, 1985); therefore psychotic symptoms manifested in one of the family
members. The father was very upset by James’ inability to maintain his role in the family due to his illness. James recounts his father’s continuous insults to him because he is not working. This is regardless of him still doing his best to make sure that there is food and other amenities. He still worries about his other siblings, especially his younger sister back home. He used his disability grant money to ensure that every one is taken care of. His father uses his pension money for alcohol. In spite of James’ illness, the family system has found ways of re-grouping and continuing with life. Even in sickness, family members still aspire to perform roles that are bestowed on them by the family system.

Third family

Leseka

...that was the time when I was hearing the voices. Yes, that was the time when I was hearing the voices. They were very intense at that time; it felt like they were people...these people were talking but they were inside my ears.

Leseka is a 57 year old man who has been diagnosed with schizophrenia since 1995. Leseka is married to Pumla and they have three kids together. Leseka was recommended for the study by the psychiatric nurse. Our first contact was two weeks before the interview and I explained the aims of the study. He chose his wife as the family member to be interviewed. He gave me his wife’s number and we agreed that he will talk to his wife about the study so that she is not surprised when I phone her. The interview took place in summer but he was dressed in a thick brownish grey oversized coat. He had a ‘permanent’ smile throughout the interview. He seemed eager to take part in the study. Our conversations took place in two separate appointments. Leseka came about 30 minutes earlier for the first interview and he
had a permanent smile on his face throughout the interview. He has three children from his marriage with Pumla and two step children from Pumla’s previous relationship.

Leseka is the youngest of three. He has two older sisters; one of them had mafufunyana but was healed by a traditional healer. Leseka’s mother was the second wife and it seems she was not getting the same attention that the first wife was getting from Leseka’s father. He was married in 1990 and his wife is very supportive. According to Leseka, his wife, his children and the church are his only support system. He has a very good relationship with his children Leseka passed grade 8 and was working as a messenger for 21 years at a government department. Lesekais on incapacity pension since 2000. He gets about R2 000.00 a month from the incapacity pension. Leseka is hoping to go back to work as he feels that the incapacity pension money is not adequate to provide for all his family’s needs. Leseka grew up in a rural area about 150 kilometres from Soshanguve; he came to Soshanguve during his early adulthood. Leseka thinks that his illness was caused by financial stress.

**Pumla**

*I didn’t know anything. It was the first time I heard about such a thing; about such a disease. They explained to me, that doctor sent me to Ga-Rankuwa. As the doctor was explaining to me he said you see he has now dropped to this level. For the illness to get better it will take a long process.*

Pumla is 52 year old and is married to Leseka who has been diagnosed with schizophrenia since 2005. Pumla was contacted telephonically a week after completing Leseka’s interviews. Pumla had a warm personality and rapport was easily established. There was no discomfort and after signing informed consent, she immediately started to describe her husband’s illness. She was dressed flamboyantly; she had a bright green dress,
fishnet stockings, high heels and an elaborate hairstyle. She was heavily made up. Her flamboyant external appearance was in stark contrast to the husband’s dowdy dress style. Pumla says there is no history of mental illness in her family. Her parents have been very supportive to her since her husband became sick. On the other hand, Leseka’s family blames Pumla for his illness. They say that he was fine when she met her and they think that she might have bewitched him.

Pumla has certificates in theology and trauma counselling. She is currently studying to further her theology studies. She is doing evangelical work full time and she is of the opinion that prayer helped her throughout her husband’s illness. Pumla says the last few years have been extremely stressful; her daughter died suddenly from an unexplained illness a year ago. According to Pumla, Leseka was severely affected by his step-daughter’s passing. She believes that it is through God’s grace that they did not fall apart. Pumla is currently recovering from a fractured ankle. She feels that all these tribulations are a test to her faith. Leseka’s illness affected their intimate relationship. She says having to share a bed with a husband who is not able to perform sexually was not easy to deal with. However, she prayed to God and her carnal needs were subdued. The following is Leseka’s genogram:
Figure 5: Genogram for Leseka
Family dynamics
Leseka’s father was in a polygamous marriage. His mother was the second wife and his father spend most of his time with the first wife. There seem to have been a disconnection between Leseka and his father. He does not remember when his father died and what the cause of his death was. Information about his father and their relationship is vague. According to Leseka’s wife, his parents were divorced; however, Leseka His wife describes the relationship with his mother as enmeshed. He was severely affected by his mother’s death and it took long time for him to recover from the loss. He was timid and aloof as a young boy who struggled to make friends. His wife states that before his illness, Leseka was extremely tidy and particular about how things are done. He got awards at work for being meticulous in his work. Leseka’s wife says that he is also very close to his sister. However, according to his wife, since he became ill his sisters never came to visit or showed any interest in his health. He claims that his sisters are very supportive and they visit often. The relationships that he has with his family of origin seem pseudo-mutual. There is an outside appearance of closeness but in reality there seems to be some distance. There seem to have been chaos in Leseka’s family of origin. Mother was lonely because father invested his time and affection in the other family. In order to create order in his life, Leseka became extremely tidy. He got married and he became the responsible provider. However, he was not able to keep up with the providing role as the mortgage was too high and unaffordable. Leseka’s attempt at maintaining a neat and ideal family life was threatened. He repeatedly stated that not being able to honour his financial obligations is the cause of his illness. He stopped being neat and methodical; he refused to bath and change clothes. At some point, he spent almost three months in bed.
According to Laing (Goldstein & Strachan, 1987) schizophrenia is a logical reaction to an illogical family reaction. If one looks at Leseka’s ‘messy’ family of origin and how he tried to create order to the ‘mess’, it is probable that his inability to maintain the order in his nuclear family might have resulted in the symptomatic behaviour that ensued. His untidiness as a result of schizophrenia was a way of commenting on his family of origin’s dynamics.

**Summary**

This chapter presented the story tellers and their families. The family dynamics discussion of each family is an attempt at revealing possible hypothesis in order to understand schizophrenia symptomology from a family systems perspective. Over the years, families and mothers in particular have been blamed for ‘creating’ children who are schizophrenic. The ‘schizophrenogenic’ mother is one example of how psychological theories labelled mothers whose children developed schizophrenia. The discussion of family dynamics in this chapter is a non-judgmental attempt at explaining the relationships that are apparent in these families. The next chapter explores the sub-themes that emerged from the conversations with the story tellers.
When suffering knocks at your door and you say there is no seat for him, he tells you not to worry because he has brought his own chair.

Chinua Achebe, Things Fall Apart
Chapter 12

*Senses torn apart, Held together by a dream, Madness is the cure.*

David Holloway, Suffering (2011)

Findings

This chapter focuses on the different themes and sub-themes that emerged from the conversations that I had with the story tellers. I immersed myself in the text; re-read the transcripts and re-listened to the audio-tape several times. I listened to the audio-tape several times without writing anything; I reflected on the stories and the process was a forward and backward exercise as the sub themes were extracted from the main themes. I spent a lot of time with the text; I wrote down whatever idea sprung to mind and I made a note of the themes that became clear to me at that time. In the beginning the text seemed so messy and there were so many meanings that seemed to emerge from the text until the re-reading and reflecting process occurred. It felt right later when meanings jumped out from the text and there was no doubt in my mind what the text was saying. The aim of uncovering the experiences and meanings that people who are diagnosed with schizophrenia attach to their illness and how their culture informs their understanding of their illness was demonstrated in the stories. The word text and stories will be used interchangeably when discussing the findings. The following is the discussion of sub themes that emerged from the stories. In an attempt to capture the story as relayed by the story-tellers, I have quoted anecdotes from the stories. Some of the story-tellers spoke English during the conversation; the exact words they used in English are underlined to distinguish them from the translated ones.
Facing the Unknown

First encounters with schizophrenia was puzzling and upsetting for the family members. They did not know what was happening or what was wrong with their ill family member. Pumla recounts the moments when her husband first started acting weirdly:

*One day when he came back from work, he refused to sleep saying that people are trying to kill him. He had his shirt off... he started saying that these people...these people...I couldn’t see the people he was referring to. He kept saying that these people want to kill me. He took the Bible and put it in the middle of the door way; he kept saying here they are, they want to kill me. I didn’t understand what was happening; I tried to get him into bed but he kept seeing those people.*

Mary remembers her brother’s behaviour when he started being ill:

*He was not talking; yes, he was not talking at all. The growth disappeared when he got to the hospital. He didn’t talk all. He was totally quiet; all he did was smoke cigarette all the time. You could see that he was not well; he was chain smoking. He didn’t say anything; when you called him, he just came to you. You could see that his mind was not there.*

Thembi says that they believed what the doctors at the first psychiatric hospital that they went to that Sindi was fine; she did not have a mental illness. She says that her behaviour was not odd, she was not crazy. However, when she relapsed and had to be admitted to the hospital and a confirmation of schizophrenia was made, the family was surprised. Thembi’s initial confusion about her daughter’s illness is noted in this comment:

*They then told us to take her to Weskoppies because as far as they were concerned, she was not crazy as she was able to tell you about what happened yesterday. The doctor said that because she remembers about what happened yesterday, she is not*
crazy. The doctor told us to take her to Weskoppies for further investigations. They checked her there and...

Thembi struggled to process the idea that her daughter has schizophrenia. She knows and accepts that she has a mental illness but at times she has doubts about the reality of the illness. Initially it was not clear whether she had a mental illness or not and this dialogue, which took place towards the end of our conversation illustrates the confusion:

**Thembi:** I just wonder why they didn’t admit her at Weskoppies when she went for assessment.

**Monama:** Do you want to know why she was not given medication?

**Thembi:** Why didn’t they admit her?

**Monama:** I don’t know. Maybe at the time...

**Thembi:** They never gave her anything. Even the Dr at Weskoppies said that this person is not crazy.

**Monama:** So are you doubting her diagnosis, you are not sure if Sindi really has a mental illness.

**Thembi:** That is what that doctor said. Those are his words.

**Monama:** The way Dr Modise explained the illness to you...

**Thembi:** Dr Modise told us that this illness presents differently. Maybe the type that Sindi has is different from the others and that is why some white doctors struggled to identify it.

Elizabeth Kubler-Ross (1969) describes the five stages of grief as denial, anger, bargaining, depression and acceptance. These families went through what seems similar to the stages of grief. Initially there was denial; Thembi felt that Sindi seems normal so she does not have a mental illness. The initial challenge in getting a correct diagnosis also reinforced her belief that her daughter is fine. When she realised that Sindi does have schizophrenia and
the doctor explained the condition to her, Thembi was angry at her ancestors for inflicting the illness on her daughter. She appealed to them to spare her family and to stay away from her family. The acceptance stage took place when the symptoms of schizophrenia subsided and she seemed to be able to carry on with her life. Sindi being okay contributed to Thembi’s ‘okayness’ with the illness. Pumla went from being sad that her husband is such a changed person and that she had to take over his role as the head of the family to acceptance that God is with them and everything will be fine. Mary on the other hand was angry that the illness changed not only her brother’s life but hers as well.

**Being Connected**

*The African thought holds that created beings preserve a bond one with another, an intimate ontological relationship. There is an interaction of being with being...this is more so among rational beings, known as Muntu... (Temples, 1959, p. 104).*

Human beings have an inherent need to be connected to others, therefore, the participants in this study are no different. In African ontology, a person as seen as being part of the larger community and the Ubuntu concept, which forms an integral part of what being African is, reminds us how to be. Mbiti (1969, p. 108-109) says this about Ubuntu:

*In traditional life, the individual does not and cannot exist alone except corporately.*

*He owes this existence to other people, including those of past generations and his contemporaries. He is simply part of the whole. The community must therefore make, create, or produce the individual; for the individual depends on the corporate group ... whatever happens to the individual happens to the whole group, and whatever happens to the whole group happens to the individual.*

*The individual can only say “I am, because we are; and since we are therefore I am”.*

Eze (2008) adds that to be a person entails recognising that my subjectivity is partly constituted by other person with whom I share the social world. Therefore, one’s humanity
depends on the appreciation, preservation and affirmation of the other’s humanity. The notion of Ubuntu is further embodied in the African proverb that states: *Motho ke mothe ka batho* (this is loosely translated as a person is a person through other persons).

**Being part of the community**

_In the African understanding, human community plays a crucial role in the person’s acquisition of full personhood (Menkiti, 1984, p. 179)_

Coetzee (1998) describes a community as an association between men and women who have a special commitment to one another and who have a developed sense of their common life. For Black Africans, the relationship they have with the community is very important. Being diagnosed with schizophrenia was for some participants a connector with the community and for others they felt disconnected with their community due to their illness. James’ illness created both a closeness and distance with his hometown community.

We have discussed the elderly lady who adopted James and took care of him. James was made to feel different by others in the community and he says:

_Yes. People talk...they talk a lot. They say I am crazy; it hurts a lot when people say that about me. They are the ones that make me get all messed up; especially people in my home town._

James added that:

_It is usually the youth. These young boys are naughty and they keep saying that. They were saying that I have a mental illness and I shouldn’t be staying in the community._

_They said that I belong and should stay in hospital._

There were other instances when he the police had to be called to assist her sister in getting him to the hospital; especially when he got violent and out of control. Mary painfully recounts what happened that day:
I was so hurt at the way the police forced him out of the van; he was so uncontrollable and angry. I was scared (crying) that they were going to physically hurt him. I asked them to leave him and told them that I will get him out of the van (sobbing).

The police did not know how to handle him and Mary says that when they arrived at their home they were scared of him; that seemed to have been the stereotype that people with schizophrenia are dangerous.

When James moved in with her sister in Soshanguve, the community accepted him unconditionally. Mary says:

You know there are different kinds of people... some people are supportive. They told me that should I need any assistance with my brother... to get him to the clinic... or at night if you want us to come and restrain him... They know that he is my brother; even when I am looking for him, they know where he is and they will tell me. At times when he wants to cut his hair and it is in the middle of the month, they will cut his hair for free.

For Sindi, schizophrenia distanced her from her community. She feels that people will judge her if they knew that she had a mental illness. These are her feelings regarding her inability to connect with the community:

Because I never disclosed publicly to people, I am still... I think I will feel embarrassed.

Because me, I... I talk to somebody I don’t know and its easy. Because I will say... you see here in my community, I won’t say, hay, I get a disability grant. But when I meet someone I don’t know, I would be able to say, hay, I am here to draw my disability grant. I can tell someone who does not know me.
You see I have already seen how people who know about my illness treat me. How they treat me (sobbing). So how are they going to treat me...And Mam you know...everyone in the family know...

You know how other people treat you and it hurts you.

So you see... Even if you tell the community, can you see the kind of feedback one is getting.

That is my only challenge. That is, even at work you can’t talk. They are going to degrade you, whatever you say.

Thembi (Sindi’s mother) is not so sure if whether her neighbours know about Sindi’s illness. She mentions that: They accepted her with her illness... I think... they don’t know that she is ill. They just see her... here they just see her.

Thembi explains how hard it was for the family in the beginning to deal with Sindi’s illness publicly and the neighbour’s perception of Sindi’s illness. Sindi has mentioned the embarrassment she feels about her illness but it seems that the family as well struggled to redefine its position in the community after Sindi fell ill. The family was viewed in a specific way by the neighbours and their position was highly regarded and having a daughter with a mental illness was challenging. These comments embody Thembi’s thoughts concerning that:

You see where we stayed we were a bit well of that the others, we had a better life.
They used to call my place ko makgoweng (white people’s place, meaning a place of opulence).

Thembi is also of the opinion that Sindi stayed behind in Soshanguve because what they thought the neighbours will say about her illness.
People didn’t take it well, so when we left she decided to stay behind in Soshanguve.

She didn’t want to return to M with us.

Leseka is an introvert; however, he had a colleague who made an effort to connect with him. He seemed to appreciate those few minutes they spend together during their lunch break. He says:

…I didn’t have many friends. There was this guy who was just a friend. He would sit with me when he was not busy. His work needed him to be on the go the whole time, therefore, we only had lunch time to discuss and talk about this and that.

He felt that people didn’t understand how it feels to hear voices and not be well. He recounts several instances at work where this lack of understanding manifested:

You see, sometimes I would take leave days and… they didn’t believe that I was ill. I would ask leave days just to stay at home and rest.

Others understood, but others were not, people are not the same. There are others who understood that this was a serious illness

Leseka adds that those who understood his illness tried to reach out to him. They made him to feel that he is part of their world and he matters. He says: “They would have conversations with me”. Just having someone talk to you seemed enough for Leseka. Pumla on the other hand felt that the community was ostracising them. They labelled her husband crazy: “They took him like he...he is crazy, he is a crazy person”. They also made unpleasant comments about his untidiness and they blamed her for not taking good care of her husband. They didn’t understand that it was part of his illness and that she tried all the time to get him cleaned up. She says:
They were never supportive. I remember at some point they were saying that they saw my husband walking around naked. I felt very offended because it felt like they insinuated that I didn’t look after him, however, I forgave them.

For the participants and their family members, being diagnosed with schizophrenia was both a ‘connector’ and ‘disconnector’. This theme will be discussed under the following subthemes:

**Being taken care of**

James’ mother played a very significant role at the beginning of his illness. The connection that he had with his mother was profound and he knew that his mother will always be there for him. Mary, James’ sister states that:

I phoned my mother to tell her how bad my brother was; my mother immediately came and fetched him once again to go back home. My mother took care of my brother; even when he was here in Pretoria, she always came for him when he was ill.

There were other people who took care of James and they made an impact on his life especially when his illness was still severe. For example Mrs Mogase, who was an elderly female neighbour always made sure that he had cooked food every day. James says about Mrs Mogase:

She was very understanding and supportive. She died though; yes, she was the most understanding… she really understood what mental illness is.

However, Mrs Mogase passed away but her husband took over the nurturing role that the wife played in James’ life. James mentions that:

Her husband was still around so he was there for me. However, the husband left and came to Pretoria to stay with his children. I think that is when I started getting ill again.
James recounts how hard it was for him to cope after Mr Mogase also left him. He had to take care of himself now and it was not easy:

“It was very difficult for me; I really struggled. Mhm… I struggled. You have to eat on time, if you don’t the pills causes some abdominal discomfort. When you get there… there was something to eat. But then when there is always nothing to eat… I used to cook in the morning, however, when you return in the afternoon, all the food has been eaten. Having to start cooking was so time consuming.”

James’ family was not able to offer him the nurturing that he got from his neighbours. It seems like his sister also needed to be taken care of and his father did not care about anyone else. He says:

“Back home… my sister is not well so she does not cook when she is supposed to.

There are times when there is nothing to eat; when I wake up in the morning I find that there is nothing to eat … my sister hasn’t cooked. Yes, she is also not well. She has… they say she has pressure (depression). I would then have to cook and take my pills thereafter. Yes.”

His comment about his father is that: “My father likes alcohol a lot… He doesn’t care much about anything else. He doesn’t care if there is food in the house.”

Being connected is very important to James and the alienation between him and his father is very distressing to him. He says:

“I wish that someone could explain that… he knows… they have explained to him that I am ill. Mhm. He just doesn’t want to understand; his only concern is alcohol. He doesn’t care about anyone’s illness and how they feel.”

Mary is also concerned by the lack of understanding and support that James gets from their father. She says:
My father does not understand that my brother is ill; he says he does all these things on purpose. You see when a parent does that...you see there is no hope. It feels like there is no way out of this bad situation and relationship.

The rivalry between the two has been very difficult for Mary to deal with; especially during the time when they were both in hospital. She comments:

He asked me where my brother was and continued telling me about his ear and that it is nowhere to be found. He said that he thinks that my brother swallowed his ear because they looked for it all over and cannot find it. I just kept quiet and thought about how bad our home situation is; the conflicts, the fighting... My father said that he wants nothing to do with my brother and he should never set his foot in his house. I knew that when my father says something he really means it.

They were fighting all the time with my father, to tell you the honest truth, my father and my brother never saw eye to eye. I want to tell you the truth, the only truth, this conflict between my father and my brother possibly contributed to his state of mind.

I was always aware of the situation at home; the constant fighting and arguments.

The fight escalated up to the point where he bit my father’s ear off.

James’ sister, Mary, took over the nurturing role that their mother fulfilled. She feels that it is her duty to take care of James. She says:

I am doing my best and I know that no one will be able to do what I have done. I am doing what my mother was doing.

In order to make sure that he was fine, especially in the beginning when he just moved in with them she would be there all the time.

I used to watch him all the time to make sure that he doesn’t hurt himself or us. You know if someone has bitten off someone’s ear off; you get worried that he might do
something like that…either to people in the street or… At that time I ventured out in the street, I was always at home watching over him.

Mary connects more with her brother than any other sibling. Even though there are times when she is ambivalent about being the care taker, there is a strong bond between the two of them and a deep fondness that is echoed by her comments:

Yes. We have a good understanding of each other. We understand each other. We have the usual sibling rivalry but… even when my mother was still alive, I was the only one who was able to make him … I remember he would at times refuse to eat but when I ask him to eat, he would eat without any arguments.

I know that my brother understands me well, I am the only one that he listens to regardless of how aggressive he is…he listens to me.

Yes. But it is not like I have a choice; I would rather not be staying with him.

When James came to stay with them, he became an important part of the family. Mary reports that her children, James’ nephew and niece enjoy spending time with him. She says that:

The other thing is that my kids love their uncle to bits. They are always having conversations with him and asking him things. They would talk for ages and laugh...

Sindi describes her partner as very understanding and non-judgmental; he stood by her and pursued her even though he heard people saying that Sindi was ‘crazy’. He is the only person who is currently connected to Sindi. She says that he is the one who collected her medications when she was not able to do so herself:

And when I was working in Bloemfontein, I asked my partner… I told him to tell the staff at the clinic that I am working in Bloemfontein. They must give him enough pills because since I am contract worker, I can’t collect my pills...

But the person I am able to talk to all the time is my partner. I don’t hide anything from him. I tell him “Puleng does this and that, so and so is doing this and that”.
Sindi further states that she feels very comfortable talking to her partner about her illness and she says:

*So when I came back from M and started taking treatment, it seemed like there were snakes all over. I then said my partner, “You see what happens when I don’t take pills”. But he understood that that was part of the illness. Yes it is part of my illness. I know that it is part…I know that if I don’t take them, I am going to be like this.*

Sindi finds it easy to vent out any frustrations she has to her partner; she seems to connect more deeply with him than she does with her family. Sindi’s sister, Ntombi is the only person in the family with whom Sindi feels connected. Unlike the emotional connection that Sindi has towards her partner, her sister is there for Sindi from a financial point of view. Ntombi is the one that always makes sure that Sindi is taking care of financially. Sindi says:

*She is the one that visits frequently. I would say to her “my little sister, I have nothing in the house”. Sometimes you find that you don’t have money, she will deposit R2000.00 or something. She will then tell me to go buy groceries for the house.*

*She is the one who took my CV and she will tell me to go to different places for interviews. “I have found a job, Ok here is the money R10 000.00. You buy yourself a bed, fridge, and all that other stuff”. And there and there... But now the contract has expired. Hey sister, contact has expired, don’t worry I have your CV.*

The connection that Ntombi has with Sindi seems to be on an academic level as well because she has a psychology degree. Ntombi is also the only one who is able to comment about Sindi’s illness to her mother. Thembi, Sindi’s mother, says:

*...the only one that said something about S’s illness is Ntombi. Perhaps the fact that she did a psychology degree makes it easier for her to talk about things.*
It is apparent that for Sindi’s family there are connections and disconnections. The disconnection manifests in the discomfort that family has towards Sindi’s illness and how none of them ever commented or spoke about Sindi’s illness. It seems like the illness is a taboo subject in the family. This had led to Sindi preferring to keep her illness and how she feels away from her family. She repeatedly says that the issue with disclosing her illness has not been discussed with the family. Even when she felt uncomfortable when her siblings shared things about her illness with other people she did not have the courage to confront them. She says:

*I think to myself, to discuss with other people; and telling them about your own sister.*
*I never told her not to tell others. Because by the time I was sick, they were staying in M. There was never time to discuss how to deal with the disclosing part.*

Leseka’s support and care came from his wife and their children. He says:

*My wife really tried to be there for me the whole time. She will accompany me to check-ups at the hospital and the clinic. She was always there.*

Leseka seems to be a reserved person; even before he got ill he did not have that many friends. He mentions the social club men with whom he related with occasionally but who were never really close to him. He describes their relationship as:

*There was this guy who was just a friend. He would sit with me when he was not busy.*
*His work needed him to be on the go the whole time, therefore, we only had lunch time to discuss and talk about this and that.*
*Men in the community… there weren’t any. Something that we had... Before I started hearing voices, the only men around here that I associated with were men that were in my social club. I belonged to a society (social club) here at Block JJ. So I associated with these men before the illness started.*
It is true, I didn’t have friends. The only reasons I would call them friends is that we met during the social club meetings.

The thing that I like about him is that he doesn’t go to anyone's house; he does not have friends. He is always in the house.

My family was very supportive, especially my mother.

According to Pumla, Leseka’s wife, his family were was not supportive. On the other hand Leseka felt that his sisters were supportive enough. Perhaps the difference in perception of family support could be to the fact that these are two different families and what is seen as supportive to one family could be seen as no support from the other. So it could be about each family’s reality regarding support and caring. Pumla states that:

His family ...his family wants nothing to do with him. Since he fell ill, no one came to check on him. I struggled with him all by myself with no support from his family.

Leseka on the other hand is quite satisfied with the support that his sister is showing him: My sisters ...yes. They understood and they frequently visited us.

Being Spiritual

For all the participants and their family member, spirituality played a very significant role in their lives. Being spiritual made it easier for them to make sense of their struggles with mental illness. They found solace in the knowledge that their suffering had meaning and that prayer will get them through whatever challenges they are confronted with.

Leseka and his wife Pumla are very religious; they are both involved in evangelical work and the fact that Pumla’s work entails praying for healing and miracles, made them believe that God is on their side. There were several challenges in their marriage due to Leseka’s illness but Pumla persevered and believed that the all-knowing and the ever-present God will come through for them. She says:
Yes. I wanted him to be healed. Have you even seen that someone prays for other people with good outcomes and then when there is a situation like this ... I said God, we are the type that cannot heal themselves. We are... we get healing. The healing that I am able to spread outside let it also be revealed in my own family.

The medical doctors told her that her husband will never be the same again because his brain was damaged; however, Pumla never stopped praying nor giving up. She believes that the power of prayer will change their situation.

I continued praying. I pray for people to get well and they do get well; and now that my husband is not well I cannot just sit and do nothing. So I prayed every day, I laid my hands on him; I knew that God will hear my prayers. That is when I started seeing some changes.

Pumla adds that:

It’s only prayer. I never consulted with psychologists; I was just praying. I prayed that God should help me; He has given me a companion; He has a purpose for all this and He knew that things will end up this way. You know that we don’t plan our lives; God has plans for us; He knows very well. He knew before conception; He knew before we were formed; He chose us... so I said that the way I found him....

Leseka also believed that prayer and the church helped. He says: “Yes, they prayed for me...on several occasions. They really tried to fight this depression issue”. Leseka concedes that even though the church may have contributed to his healing, what really helped was treatment from the medical doctors. He states: “There was help there but what really sorted out my problem was treatment from the medical doctors; yes the pills and the injection”.

Pumla believes that the connection his family has with God has been vital in their survival. God was there when they were hungry and He made sure that they get help. God used other
people to help them; she says: “Yes. I have a car now that was given to me by someone; others buy us groceries. Life goes on. Currently I don’t think there is a problem”.

Pumla reiterates:

*You know God is making wonders… there is this woman who is a business lady…I helped her with her problems and now she is really helping us financially. I cannot complain; even the pension that he is getting we don’t rely much on it. This woman would just draw big sums of money and give to us to buy groceries and stuff.*

For Mary, being part of a prayer group helped her deal with her challenges pertaining to her brother’s illness. She says that being part of the women’s prayer circle was very helpful for her because they understood what she was going through and she felt comforted by their presence. She says:

*I go out and talk to people. When I share my trouble with others, it gets better. I get 100% better. When I am with other women, I forget about my situation. Sometimes I share my troubles with them and they give me some advice where they can. I go to church; I go to prayer meetings and that is all…*

*We share a lot of stories. We would talk about this person who was lying in the house…at the pool and Jesus healed him. So you have to confess and say that you are ill and everyone will know that you are ill.*

James on the other attends church occasionally. When asked if he consulted the church for his illness he mentioned that he does go to church.

Sindi’s mother does not believe in traditional healing practices therefore, the church played a very important role; especially during the beginning stages of her illness. She says that pastors came to their house to pray for her healing.
They prayed and prayed for me. But my mother said that she is happy that she took me to the hospital and I am healed. And the people who said I must take you the traditional healers, I will say to them that here you are, I took you to the hospital.

Sindi’s mother on the other hand felt that she couldn’t even trust the African church’s interventions. Her aunt took her to a church for healing and Thembi was reluctant, she says:

She took her to some prophet, I didn’t go with them. Actually I didn’t want her to take Sindi there, but I was not brave enough to say that to her. I just said that I am not going there. I feel that I did what was needed; I took steps and took her to the hospital. From there …I don’t think there was anything else that needed to be done. I am not really keen on the use of traditional medicines; I don’t like them.

**Being Without**

A diagnosis of schizophrenia brings with it changes in the lives of those diagnosed with the illness and their family. There are many fundamental losses that were experienced by both the family and those diagnosed with schizophrenia. The following is a discussion of the different facets where loss was felt.

**Independence**

James feels that if he was not ill, he would have been able to take care of himself. He states that he wouldn’t be staying with his sister. James says:

*There are lots of changes ... work ... I haven’t been able to work since. Everything fell apart. However, I am so grateful that I am getting a disability grant.*

*I am currently not working because of the illness. I would still be working if it wasn’t for this illness. I would still be working, yes. I would be staying in my own place ... yes I would be staying at the hostel in Mamelodi.*

James also feels that he might have been married as well. The fact that he is not working and not earning enough money makes it difficult for him to marry someone. He says one needs to
earn a certain amount of money in order to provide for a wife. The disability grant is just enough for provide for his own needs.

\[\text{It is money. There is no money. I wouldn’t want to marry someone and not be able to provide for them. It won’t be a good thing. There is no money. Yes. If I was not ill, I would have been married and I would have had my own house.}\]

Mary initially struggled to adjust to her new role of care-taker. She says there was a time when she wanted to send her brother back home. She was forced to stay at home and watch over him because of his erratic behaviour. She says:

\[\text{I used to watch him all the time to make sure that he doesn’t hurt himself or us. You know if someone has bitten off someone’s ear off; you get worried that he might do something like that... either to people in the street or... At that time I didn’t go out in the street, I was always at home watching over him.}\]

She further adds:

\[\text{Unless my other brother take over caring for him; but I know that he won’t stay longer than three weeks with them. But it is not like I have a choice; I would rather not be staying with him.}\]

Leseka’s financial independence was affected by him not being able to continue working. He says that the sick pension that he is getting is not enough to sustain his family’s financial needs. The following comment is a response to what going back to work will mean for him and his family:

\[\text{You know sometimes there is no food... foodstuff runs out. Sometimes you also have to pay for electricity; the electricity bill has to be paid, and that becomes a problem. The bill fluctuates, sometime very high and sometimes low; that really is a big problem.}\]

Leseka adds that being ill made working a challenge.
It disturbed me…eh…it interfered with my ability to can still continue working. I had challenges at work; it was really not nice…

Leseka’s wife on the other hand feels that he does not have to go back to work as they are getting the financial help from people that she prays for. She blames his work partly for illness.

*He mustn’t go back; they are going to condemn him again. We are fine financially, we not going hungry. There is money for food and clothes so I don’t see the reason for him to go back.*

Having other people provide for his family might be reason why he feels the need to go back to work; he wants to reassert his position in the family as the provider. He is planning to resuscitate his career even though his wife does not agree.

Sindi was working at one of the big banks in the country when she fell ill. She had to resign due to the illness as her paranoia was affecting her performance at work. If she stayed on, she would have been up in the ranks of the company. She says: “*If I didn’t leave ABSA, I would have been far in my profession*”. She is getting a disability grant at the moment, which is a far cry from the salary that she would be earning if she was still working at ABSA. Sindi is currently writing her board examinations which will allow her to practice as a lawyer if she passes them. However, she feels that if she was not diagnosed with schizophrenia, she would have been far in her career. She says:

“*I don’t know. I have money in the bank. I am still planning my future*. I…my life would have been far, far, far, away. Because I am still picking up the pieces. You understand me, maybe I wouldn’t be here, I would be somewhere…I don’t know where…I don’t know... (sad voice).
Thembi was forced to take care of Sindi’s daughter because Sindi was incapable of doing so herself. During the early stages of her illness, Sindi had thoughts of harming her child and that is why the doctor who was treating her at the clinic requested her mother to take the child away from Sindi. Thembi had to adjust her life and accommodate the two year old child. Her daily routine as a hawker had to adjusted; her grandchild had to be taken to the crèche in the morning and in the afternoon special arrangements had to be made for her to be collected. Thembi is now used to taking care of Sindi’s daughter, and because she is older now (she is currently 12 years old) it is easier. She says:

*I would go to the fresh produce market, buy my stock and go to my stall and sell fruit and vegetables. It is because of her that I am used to juggling care-taking and my work. I am currently taking care of my other daughter’s child. It is much easy now.*

**Relationships**

The diagnosis of schizophrenia changed how people related with their family member who had schizophrenia. There are other family members who lost the potential for relating with others because of the relationship they have with their ill family member. Mary is still single and she feels that having to take care of her brother made it difficult to pursue intimate relationships. Taking care of her brother used to be a full time job. She says she might not have been able to take care of her brother if she was married. She thinks that perhaps she was predestined to be without a companion:

*If I was married, if I had a husband, do you think that my husband would have allowed what is happening now? My brother would have long been gone back... I think God knew that my brother was going to be ill... my family was going to be the way it is. I think that maybe I would have had someone next to me.*
James’ relationship with his father has been marred by his illness. In 2011 he had a big fight with his father and he bit his ear off and since then, his father does not want anything to do with him. Mary says:

*My father does not understand that my brother is ill; he says he does all these things on purpose. You see when a parent does that…you see there is no hope. It feels like there is no way out of this bad situation and relationship. ...Those two can’t share... they can’t be in the same space.*

Sexual relationship between Leseka and his wife changed due to his illness. He lost his ability to perform sexually and he thinks that the reason to reduced sexual performance is due to the side effects of the medications. Since he has been ill, he struggles to get an erection and that is frustrating to both him and his wife. Pumla says:

*Mh…especially….when it comes to sex. Yes the sex part. You know one thing that I asked from God ...I said God please help me ...please suppress my sexual feelings until my husband is okay. Sometimes there is some activity and then we are able to do... you know and that will be all...Sometimes things work out and we will have sex, but most of the time no. This has really affected him; when it comes to matters of sex he is really affected.. I think the fact that for a long time I was not able to engage in regular sex damaged me. For about five years we were sleeping in one bed without any sexual activity.*

Pumla adds that:

*...some women struggle to stay in relationships where there is no intimacy, however, I stayed with him like this (showing with two fingers), sleeping in the same bed with him and there was no action from his side.*
Loss of health

Having schizophrenia means that your state of health is not the same as it used to be. Leseka repeatedly stated that his mental ill health made his body weak; that made it difficult for him to do things that he used to do before. For example, he was a very active person who got awards at work for good performance. However, since being ill, he struggled to get to work on time. He says:

*Because when the voices were at their loudest, you just didn’t know what to do; your body just got weak... your body got worse. At work... I tried to do the best I could. But I didn’t have...what is that called...energy. That showed that I was not well. You see, sometimes I would take leave days and... they didn’t believe that I was ill. I would ask leave days just to stay at home and rest.*

Leseka comments that:

*That is how the voices would operate; they were very strong and my body was weak.*

*It was weak, weak, weak. At that time, I could hardly walk.*

Since then, things were very difficult. He couldn’t wake up in the mornings and he would always be late for work. His employers called me and told me that what is happening to him is affecting his work.

Loss of intimacy

According to Pumla, since Leseka became ill, their sexual life changed tremendously. They both state that it is the other partner who is more affected by the changed sexual performance. Pumla’s comments illustrate the ambivalence:

*He is the one that is more frustrated. I don’t have issues with sex, I don’t have issues.*

*I think the fact that for a long time I was not able to engage in regular sex damaged me.*
On the other hand Pumla acknowledges that it is not easy when things are not going smoothly in the bedroom. She says:

...some women struggle to stay in relationships where there is no intimacy, however, I stayed with him like this (showing with two fingers), sleeping in the same bed with him and there was no action from his side.

**Being a parent**

Sindi had to give up her role as a full time parent to her daughter. Due to her illness, she had to hand over her parenting responsibility to her mother when her daughter was only two years of age. She says she did not cope with being a parent and that time she felt that her daughter caused all the mess in her life. She had thoughts of harming her; she recounts the following:

* I could kill you if I met you. That is the way I was. Then I went to hospital, when I got there they said take the child away (her daughter). I remember I wanted to strangle the child. I was...I have a child neh, she is 12 but by that time she was four or three.

* When I was staying with her, I was close to kill my child.

Sindi currently wants to have another child but she is not sure if that is good idea. Being diagnosed with schizophrenia seems to thwart the possibility of her being a parent again. She feels that there are things that need to be considered, like the fact that the child might be affected by the medication or she might be born with a mental defect. She says: “I think that perhaps the child will be born with... I ...I think that maybe the child might be born with some disorder”.

She adds that:

* Maybe the child will... maybe the pills will affect the child. So I don’t know. I have heard at the hospital that if you fall pregnant, the doctor have to change your treatment so that your child is not born otherwise.
Sindi was unable to parent her first child due to the illness and now she is not afforded the opportunity to have another child. Her illness is now under control; she does not have the thoughts that she had in the beginning of her illness. However, she seems to resign herself to the idea that she might not have another child.

**Loss of connections**

Schizophrenia as an illness separates and disconnects those who are diagnosed with the illness from other people. We have seen how the community and other family members disconnected from people diagnosed with schizophrenia; however, there was also disconnection from others by those with the illness. James kept to himself during the earlier stages of his illness. Mary says:

*He didn’t talk all. He was totally quiet; all he did was smoke cigarette all the time. You could see that he was not well; he was chain smoking. He didn’t say anything; when you called him, he just came to you. You could see that his mind was not there.*

James feels that being in a quiet environment is helpful for him; he feels that he is able to manage what he feels in his head when there is some quietness. It seems that being quiet could have been his way of containing himself and coping with the voices in his head. He reiterates that: “*I think the main thing is that one should take care of oneself. One should avoid being in noisy places because that makes one feel bad*."

It seems like disconnecting and separating oneself from other people was intense for Leseka. In the beginning of his illness he would isolate himself from his family; Pumla reports:

*Another thing about his illness is that he would at times spend days in bed. I remember at times he would be in for two weeks; he would just stay in bed without getting up. I would bring him food in bed; he would eat and go back to sleep.*
Sindi mentioned that she was very suspicious of people and always felt that people had malevolent intentions. This made her to keep to herself because she believed that people were out to harm her. It seems by disconnecting from others made her feel safe and her paranoia was less intense. She says:

\[
I \text{ was so negative, thinking that people are conspiring against me. I didn’t speak to any of my family members. I was against any other, everyone. I would just hate them.}
\]

\[
I \text{ didn’t face reality. If I tell myself that...}
\]

**Loss of Being**

One of the most fundamental losses that was experienced by family members and those diagnosed with schizophrenia was the loss of being. The illness became a game changer in their lives and they felt that it has transformed them from who they are. Pumla complains that since Leseka became ill, the person that he was disappeared. She repeatedly says that her old husband is back and she is grateful for that; however, there are things that happened in the past which were not consistent with what Leseka is. She comments on those changes:

\[
\text{In the beginning I didn’t suspect anything; I know my husband and I never thought that he will do anything like that. He was an upright person; it never crossed my mind that he will even think of doing that.}
\]

Pumla feels that she lost her upright husband due to the illness. The boundaries in their marriage which were there over a long time collapsed as a result of the husband’s changed personhood. The other change that occurred as a result of the illness was Leseka’s disregard for hygienic practices. He was a very neat person and very particular about the orderliness of everything around him. Schizophrenia changed all that; Pumla recounts their son’s comment regarding this:
Eish mom, I am just surprised at what has happened to dad. He was okay, he was neat and now the way things are, what happened?... dad was okay and now suddenly he has changed.

Thembi feels that Sindi has changed she was diagnosed with schizophrenia.  

But when you look at her, do you think she is normal? She looks a bit disabled. It seems like the pills made her a bit disabled. Her hand... when she walks...You must observe her closely, you need to observe her closely. I think the pills that she is taking they don’t ... I don’t know...

Mary has also observed some changes in her brother James. James also has developed some tremors which get worse when he is upset or nervous. When his illness started, he chain smoked cigarettes; however as his illness progressed, he started smoking marijuana. So James changed from being a cigarette smoker to being an illicit drug user. Mary disapproved of the new habit without success. She was able to curb the extent of his usage by threatening people who supplied him with the drug. She says:

What helped me is that I told all these people who were selling him marijuana that I was going to get them arrested. If they dared sold drugs to him, I threatened them with the police. They started to send him back home when he tried to buy something from them.

She maintains that: Even now he still smokes them but he knows that I don’t want him to smoke marijuana, so he smokes secretly... But I do know that he smokes marijuana.

The most difficult challenge for Pumla was witnessing progressively how her husband changed from being someone who is neat and particular about tidiness to someone who hated bathing and insisted on wearing the same clothes for weeks. She had to share their matrimonial bed with him regardless of the smell that came from him.
Yoh! Yoh! You have no idea how painful it was for me. I don’t think most people will survive and have the patience. Sleeping with a man who doesn’t bath; who smells… I just ask strength from God. I told myself that he is my husband and I will never desert him.

What Is Behind The Bushes

Mental illness in general and schizophrenia in particular is explained differently by different people. From a Black traditional point of view, the role of ancestors and witchcraft and spirituality are significant in how mental illness is understood. There are varying explanations by the participants as what they believe caused their illness and what treatment modality they perceive to be efficient in managing their illness or those of their ill family member.

Leseka and his wife Pumla are very religious and they did not even consider consulting traditional healers for his illness. For them the church was the obvious second opinion after having consulted the medical doctors. Pumla believes that Leseka’s illness was caused by the evil spirits; she is convinced that Leseka’s colleagues have something to do with his illness. She says his colleagues were jealous of his performance at work and how impressed his employers commended his admirable work ethic. She points out that:

those spirits were saying how they got in. He was liked by everyone at work. There are big hot water urns at work; I don’t know what they put in there. He was a hard worker, so I think the aim was to destroy him.

Pumla adds that:

... after those spirits left...I think his colleagues thought that his life was going to be shattered; he was going to die or he was going to be fired from his work.
On the other hand, Pumla’s sisters-in-law thought that she has bewitched him. One of Leseka’s older sisters was diagnosed with mafungfunyane and she was healed by traditional healers. He also believed that his sister’s illness was caused by witchcraft; he says her colleagues were responsible for her illness. He comments on his sister’s illness:

*I think it was just an illness that was caused by people (bewitched). I think it was those people that she worked with when she was a domestic worker. I don’t know, maybe they put muthi in her food or something... the mafungfunyane illness.*

Leseka and his wife are also convinced that the amount of stress that he had due to financial obligations contributed to his mental health deteriorating. Leseka says that the constant worry about paying his loan hugely affected his health. When asked what he thinks caused his illness he said:

*I would say that I had stress...financial stress regarding the issue with the loan. There was just a mess in terms of finances; I was not satisfied with my finances. At work they gave me pension instead of looking into my finances.*

Pumla is also of the same opinion:

*I remember in the beginning, we had serious financial problems and on top of that my husband was not well; it was very challenging. I think that situation also contributed to his illness; I think it was the stress of earning nothing that affected him.*

James consulted several traditional healers in the beginning of his illness. Varying traditional interventions did not result in long lasting relief from his illness. The last traditional healer that he consulted referred him to the hospital and since that time he hasn’t sought help from traditional healers. He thinks their medication was inefficient and they didn’t know what they were doing. He recounts one of the visits to one of the traditional healers:
This man drank sorghum beer and kept the beer in his mouth; he asked me to take off my shirt and then he sucked my abdomen with the beer still in his mouth. He would then spit out all sorts of weird things claiming that those things come from my body. The process was repeated and those things that he spit were set aside.

James adds that:

I didn’t trust him. I just looked at him when he was spitting stuff out. His concoctions didn’t help at all. What helped me was the treatment from the medical doctors. Yes, they injected me; they injected me and gave me three months. Since then I have been okay.

Mary is adamant that there is no way that James will consider consulting traditional healers now. She also strongly states that she will not allow him to do so because of their previous experiences and how well his illness is managed now by the medical doctors. Mary also feels that going to church and trusting in divine healing is significant. She states that: “We would talk about this person who was lying in the house...at the pool and Jesus healed him”.

Mary and James believe that his illness was caused by the noise and the chemicals at his workplace. They do not suspect any malevolent forces behind his illness. Mary says:

The way I see and understand his illness, it is not witchcraft. It is ... I think his work environment was ... He was working with chemicals which are poisonous...that is how I understand his illness. It was due to the poisons. He loved his work a lot...but witchcraft? ... I don’t believe it was witchcraft.

James reiterates:

I can say that it was the noise from the factory. The noise and the chemicals...I think that is what caused this illness...there was no protection from the noise and the chemicals.
Sindi, like James, sought help from the traditional healers in the beginning of her illness. However, she feels that instead of helping her they planted wrong seeds in mind which further fuelled her paranoia. They told her that she was ill because of some evil intentions from other people. She recounts how it was for her in the beginning:

…and witchdoctors they tell me lots and lots of stories. They say there is that tree, there is a monkey; that monkey comes to you at night and I just triggered (finger snapping sound). I start now... I start screaming when I see someone, I see...I get frightened...I start...you see. I start to get frightened when I see you for example, I say (screaming sound).

She consulted two or more traditional healers and decided to abandon consulting them after the last one who was a prophet suggested to her to go to the hospital for treatment. She also has since stopped seeking help from traditional healers because she felt that the pills she was getting from the medical doctors were effective. Sindi explains what the prophet said to her:

He said I had mafungfunyane. But take her to the hospital. He said even though the other traditional healer said it was amadlozi, this is not amadlozi, it is mafungfunyane. Take her to the hospital; she must take my treatment and the hospital’s treatment.

Sindi’s mother wanted nothing to do with traditional healers and she is certain that they are the ones who made Sindi’s condition worse. She was not in favour of Sindi’s aunt taking Sindi to the traditional healers. She is of the opinion that the modern day traditional healers do not heal but are only concerned with making money out of their patients. Thembi does believe that ancestors do exist however she says that her ancestors do not prefer traditional medicine. Thembi is spiritual and she is convinced that certain things that happen in our lives are predestined. Thembi’s mother was in a mental institution from 1952-1987 and she had what seemed like schizophrenia; so when Sindi was diagnosed with schizophrenia,
Thembi thought that perhaps it is her mother’s illness that is manifesting again through her daughter. She says:

I was so hurt, I asked myself... you know what happened... I was really hurt. Even when I don’t believe in the ancestors, I took a cup and maize meal... I put maize meal in a cup and told them (the ancestors) that if this is my mother’s madness, they must just leave my children alone, please! I said to them if this is of their doing, asseblief, they should leave my kids alone.

Thembi does not believe that Sindi was bewitched; she is convinced that Sindi’s illness comes from the ancestors. She believes that when people die their spirit enters those who are born and whatever issues they had or their personalities can be transmitted to the living host.

Things Not Revealed

The challenge of being diagnosed with schizophrenia and being a family member of someone with the diagnosis cannot be over-emphasised. Different patients and their family members found a way of dealing with this illness that affects everyone in the family.

Secrets

Sindi and her family seem to have perfected the art of not saying what needs to be said. Thembi spoke about her mother who had a mental illness and her illness was hidden from them until she saw documents in the house stating that her mother is in a mental institution. Even when they found out about her mother’s where about, her family was reluctant to have a conversation about her mother. She comments on her father’s reaction when he found out that they have been to visit her mother at the mental hospital:

So my dad said if my mother comes home, we will forever be looking for her; we will be running after her all the time. And we are working, so my dad asked us if we will be able to cope with her. She is fine when she is taking her pills but she needs
constant supervision as she wanders off. So my dad said... my sister was very angry, she said let's go and fetch my mother, my dad refused.

Thembi’s mother was there but still not there. She was never acknowledged in any family decisions and her opinions were disregarded. When Thembi’s father died, the family did not include her in her husband’s estate. Thembi recounts that time when her father’s estate was shared:

*After my dad’s funeral, his estate was shared by the remaining family members. I remember my aunt asking them: “what about that one in the hospital? Is she not getting her share of her husband’s estate?”* The other family members said, no, under no circumstances. My aunt said no.

Thembi remembers how her father maintained the pretence that her mother does not exist.

*... but one thing that surprised me as I was growing up was that there was nowhere my dad declared my mother as a beneficiary, be it a funeral policy or what.*

Sindi seems to be suffering the same fate. Her voice at home is not heard but she feels that she cannot comment on that. She has resigned herself to the fact that because she has a mental illness, her opinions will always be disregarded. She says: “*the way your family treats you. It is like...somehow...they belittle you. You see*”. Sindi further adds that:

*Because sometimes you would be sitting with them, when you try to say something they...that is, they don’t take you into consideration. That is the thing that I have observed.*

Even though it hurts her being treated this way by her family, she feels she rather keeps quite about her feelings. Thembi is not even aware that Sindi feels uncomfortable sometimes when she is with the family. When asked how Sindi relates with others in the family, she said: “*No, she is fine. She does not have any issues; she is fine, her mind is okay*”. I sensed a bit of
discomfort when she was answering this question because she immediately changed the subject and commented on Sindi’s achievements. Thembi did mention that her children like bottling things up and that is why they get ill; however, it seems keeping things unsaid is part of the family rule.

Another secret in Sindi’s family is the fact that her husband’s family also have two members with psychotic mental illness. Thembi says that her husband pretends like there is nothing “wrong” with his family. She says:

I was saying that there is something that surprises me is that in my husband’s family there is... this illness is also there. There are two kids who have this illness. I told him that this illness is not only from my side of the family; however he does not want to acknowledge that.

The same as her mother who was not told anything about her mother’s mental illness until she was old enough to find information regarding her whereabouts, Sindi and the family are keeping her illness a secret from her 12 year old daughter. Thembi feels that it is Sindi’s duty to tell her daughter about her illness and Sindi on the other hand feels that her daughter is not old enough to understand about schizophrenia. History seems to be repeating itself and Sindi’s daughter is the third generation that has to deal with family secrets. Regarding the difficulty they have in telling Sindi’s daughter, Pumla says: We haven’t said anything to her. Sindi will tell her when she is ready and old enough. It is difficult for us to tell her…it is hard (soft voice).

Mary mentions the difficulty of taking care of her ill brother and how she at times wished she could send her brother back home. She kept this to herself because she knew how badly her brother was going to be affected by the decision. She also knows that there is no one else help her take care of her brother. She says:
“Just tell him that your sister is taking you home... he becomes... the tremors gets so severe that he won’t be able to hold a plate still”.

There are several things that have been very difficult for Pumla to deal with since Leseka fell ill. The following are issues that she had to live with daily:

**Being Okay**

The burden of having someone diagnosed with schizophrenia was huge for those diagnosed with the illness and their family members; however, they decided not to allow the illness to keep them down. Sindi says she is okay now as long as she takes her medication as prescribed. She feels that being able to pursue her studies contributed to her “okayness”. Her mother feels the same in this regard:

> Yes, yes. You can do whatever you want. Yes, you can do those things. It’s just that they differ (voice hoarse, coughing). It all depends on how the illness presents itself, maybe if...if she can find work...if she can find a good job, she will be okay.

Sindi reiterates:

> ...I have achieved a lot. I ... that is, I saw that I can prove myself. I can do whatever. I have the ability of doing whatever anyone who is not mentally ill can do.

Sindi initially felt that being diagnosed with schizophrenia signifies the end of her life; however, as her symptoms were alleviated by medication and she saw that she was able to do a lot regardless of her mental illness, her view about her illness changed. This comment encapsulates her view:

> You can do anything; you can study and stop depending on disability grants. Don’t say that they say I am permanently ill, I won’t do anything; I have to be someone’s burden, I have proven it. You can study, you can pass and you can understand whatever you are studying. Does not mean that if you have mental illness you can’t
understand anything written in the book. You can’t. It is their perspective; that means you are mad, you don’t understand anything. So, this illness is manageable.

So...(inaudible) you can control your feelings, meaning that when I was ill I used to do this and that; now I am taking pills and I don’t do this and that anymore. So, those things happen but you can prevent them; you live your normal life. And even Dr Mokoka told me that as long as you take your medication, you are no longer mentally ill. When you stop your treatment, then it is then that you are getting mad.

Pumla feels that her husband is okay now even when the illness has had long lasting effects on his personality. She believes that her old husband is back. Having a partner with schizophrenia seems to have taught Pumla to appreciate every small change in Leseka’s behaviour. She says that they still have an on-going battle to get him change his clothes regularly but even when he complies under duress, for her it is good enough. One of the observable changes in Leseka is the slowed speech and he takes time to find words; but his wife is grateful that his old self is back. Even when his general appearance is unkempt; his wife feels that he is okay. His sexuality was affected by the illness but she says they are okay and she is grateful that they were able to conceive three children in spite of the sexual problem. Pumla says:

Life goes on. Currently I don’t think there is a problem; the only problem though is that he does not want to change his clothes. He wants to spend the whole with the same clothes.

Pumla adds:

The one thing I am grateful to God about is that we were able to have children; I was able to get pregnant. I was able to fall pregnant regardless of his illness; even when we are not able to do it every time.
The following comment summarises everything that Pumla feels about his husband’s okayness: “For me he is all right, he is the husband that I know”. It seems that Pumla and Leseka were able to redefine their roles and she is currently more involved in the running of the household. However, Pumla does give Leseka some responsibilities like attending school meetings.

The intensity of care that Mary offered James is much less than earlier when his illness was in its beginning stage. James is now okay; he is able to draw money from the post-office on his own. James is so okay now that he is thinking of ways to help his siblings at home.

The three families have shown so much resilience and there is no shred of self-pity. They take the bad with the good and the care takers have developed coping mechanisms which has been instrumental in ensuring that the light of hope shines through the struggles with schizophrenia.

**Reflection**

The above themes tell a story of how families stand together in the midst of a storm. These are the stories of courage and love; stories of a never-say-die attitude; stories of tolerance and unwavering trust; stories of hope and the pain. It was very humbling and encouraging to hear how ordinary people go about their lives and how their families adjusted to the new ‘thing’ that invaded their family.

Berg-Cross (2000) describes the five psychological characteristics of the family. The first one is commitment and continuity. We have seen how all three families showed love and commitment to each other and the ill family member. It is evident from these stories that even though it was not easy, the connections that these family felt towards each cemented the permanence of these relationships.
The second characteristic is the potential for endurance. Consistent with the first characteristic, these families stood behind each other tirelessly. There were times when some of them felt the weight of the burden was too much but they soldiered on.

The third characteristic is multiple interactions and high intensity. Regardless of all the good that came out of the stories, there were instances when strong feelings of resentment were apparent. The ill family member seem to exhaust the resources available in the family. However, there were also feelings of love and acceptance. It is evident that family members respond differently to each other and the connections are also different.

The last characteristic is the adult responsibility for children. We have seen even when the children were adults themselves, their parents still took responsibility of caring for them. Leseka, whose mother has already died, had a wife who took over the nurturing role. The three participants were “parented” either by their spouses or in the case of one participant a sister took the mothering role.

**Summary**

This chapter analysed the stories and excerpts from the interviews were used to clarify the themes discussed. The words and the language used by the participants were used to reveal the phenomenon that was being discussed. We have discussed how participants felt connected and disconnected from their families and the community. There were losses experienced by the participants which ranged from loss of independence, loss of roles and loss of being. There were also gains which included learning to be okay when things are not going well and finding something good from something as bad and sometimes debilitating as schizophrenia. The ‘whole’ of this thesis reveals themes that will be discussed in the next chapter. In the next chapter, the overarching themes are extracted from the sub-themes in this chapter and they are discussed based on the available literature.
I understand it now
A lot better than I did
About playing the tune and dancing along
About blind ignorance and liars
A warehouse full of didgeons walking in circles
Where no one ever looses his musical chairs
Because there is always an extra chair hidden away
No ending, no beginning...

Blue Sky Lady (Minds unleashed, 2009)
Chapter 13
Discussion

This thesis sought to explore the experiences of people diagnosed with schizophrenia together with their significant family members. To attain this, there was a back and forward movement between the parts and the whole. The backward and forward movement within the hermeneutic circle enabled me to focus on the parts and the whole of the stories that the participants shared with me. The previous chapter focused on the parts of the stories as the participants revealed their experiences. This chapter will focus on the whole. It should be noted that the process of moving between parts (sub themes) and whole (themes) did not happen separately from each other, but it was a fluid backward and forward movement that took place all the time. The separation of the two in this thesis is only for pragmatic reasons. For example, whilst the participants were talking about how the illness changed their lives, the theme of loss was noted together with an overarching theme of coping. The discussion of the findings will be integrated with available literature. The following is a diagrammatic representation of how the part link with the whole:
Figure 3: Sub-themes and Themes
The Church or The Sacred Corner

In African traditional belief, there is a sacred corner at home where traditional rituals which involves the ancestors take place. This is the place where offerings to the ancestors are made. It is the place where if the family needs to communicate something to the ancestors, the elders in the family will go to the sacred corner and communicate with the ancestors. This sacred corner is called thokgola in Sepedi. In IsiZulu tradition, incense (imphepo) is burnt at the sacred corner before rituals are performed and it is seen as the only way of communicating with the ancestors (Mkhize, 2009).

Thembi felt the need to appeal to the ancestors as she felt that they were responsible for her daughter’s illness. After the ritual she was convinced that all will be well with her family. Muneno (1994) claims that there is a strong belief in many gods (vhadzimo) or badimo in SeTswana or the living dead. The living dead are explained as the spirits of those who passed the physical state of existence and have moved to the spiritual state. Badimo are believed to be a link with the supreme God and they are consulted in times of trouble (Muneno, 1994). The ancestors were seen as being alive and influencing things that happen earth. The one family strongly believed that when people die they do not disappear; they control what is happening to us. This poem by Birago Diop, The Dead Are Never Dead encapsulates this family’s thinking:

Those who are dead have never gone away;
They are at the breast of the wife;
They are in the child’s cry of dismay.
They are not under the ground;
They are in the fire that burns low;
They are in the grass with tears to shed;
They are in the forest, in the home stead;
The dead are never dead.

Thembi is of the opinion that the ancestors play a huge role in her family’s life. Like Birago Diop, she is of the opinion that the dead are never dead; they even manifest their being undead through some of the living members of the family. Nyamiti (nd) further adds that the present world is intimately connected to the world after death; therefore, Africans live closely with their ancestors and other spirits.

Motlana et al. (2004) maintain that most patients perceive the cause of their illness as being due to bad luck, bewitchment and stressors in their lives. Some of the participants in this study believed that stressors contributed to the origin of the illness. Thembi feels that her daughter would most probably be well if she did not have that many stressors in her life. Mufamadi and Sodi (2010) interviewed VhaVenda traditional healers and they also attributed ancestral dissatisfaction, bewitchment, water in the head, heredity and alcohol consumption as some of the causes of mental illness. Leseka and James also attribute stress to be a contributory factor to developing schizophrenia. For Leseka it was financial stressors and James’s stress levels emerged from the volatile relationship that he had with his father. Motlana et al. (2004) found that 60% of participants in their study initially consulted with indigenous healers for assistance with their ill relative. In this study, there are two families that sought help from traditional healers; one family consulted two traditional doctors and the other consulted one traditional doctor and one priest from the African traditional churches. Some of the families’ believe in traditional medicine waned as they noticed that the illness was controlled by Western medicine. Cumes (1995) studied the mental illness among the rural families in South Africa and it was found that some families abandoned treatment from the traditional healers as they felt that they did not get the help they were hoping for. The traditional healers in that study blamed the proliferation of healers and not enough patients.
This seems to have resulted in unethical behaviour among some of the traditional healers. This sentiment is shared by Thembi; she does not trust traditional healers and feels that the current traditional healers’ work ethic is not similar to the older ones. Cumes (1995) argues that the world of the Xhosa traditional healers in not consistent with the picture that is created by studies on traditional healing practices. Swartz (1998) points out that there is a complex and overlapping nature of people’s healing systems, practices and beliefs.

Religion plays a very significant role in the lives of all the participants in this study. Literature has shown that Africans perceive religion as being an integral part of their daily living. According to Awolalu (1976) religion has a fundamental influence in the lives of most Africans. Adeolo (2006) maintains that religion serves as a structure around which all activities pertaining to cultural, economic, political and social organisations.

Simundson (1989) is of the opinion that most people turn to the Bible when they are faced with mental health problems. The Bible becomes a significant resource as they try to find answers which will ease their suffering, reduce their depression and an assurance of God’s love and acceptance. Andreescu (2011) adds that Christians re-appropriate what is in the Bible and its testimony by focusing on scriptures that are relevant to their personal stories. Mark 11: 24 says: “Therefore I tell you, all things whatever you pray and ask for, believe that you have received them and you shall get them”. This verse and the others in the Bible which promise abundance and health was used by the family to instil hope that their prayers will be answered. Pumla firmly trusted that all they need to do is keep on asking and God shall give. This family already felt that God has given and provided for them financially.

Prayer is defined by Andreescu (2011) as a way of communicating with a divine power and Christians use it to build personal relationships with God. Pumla, who is very religious uses prayer as a life line between what was happening in her family and God. Even
during her darkest moments, she never questioned why God allowed this to happen to her family. She kept praying for everything that went wrong; she prayed that God should numb her sexual desires when Leseka was not able to perform sexually; she prayed for her husband’s healing even though the medical doctors told her that there was no hope for him; she prayed that God should grant her perseverance and understanding when her husband brought home another woman; she prayed that God should maintain the love she has for her husband when her husband refused to take a bath and was smelly; she prayed for patience when her husband spend almost two months in bed because he did not have the energy to get out of bed; she prayed for strength when it seemed like things were getting too heavy for her. She prayed all the time and she still does. Safara and Bhatia’s (2009, p. 67) quotation of Luther saying: “Prayer and nothing but prayer” encapsulates this woman’s stance on faith in God and prayer. Safara and Bhutia add that prayer can change our perceptions, and deepen our appreciation for life and it also has the ability to move the imagination into a meditative space.

One important issue that emerged from this study is that most families adopted a ‘both and’ attitude towards treatment of mental illness. They initially sought help from the traditional and the Western healing practices. Of importance in this study is that those who initially consulted with traditional healers did not continue with traditional treatment; however, the family that consulted the church, continued praying and seeking prayers from the church for healing.

**First Encounter with Schizophrenia**

According to Jungbauer et al. (2004) the onset of schizophrenia is an extremely burdening and catastrophic experience. Individuals diagnosed with schizophrenia report the feeling where one is not being able to control one’s thoughts as being terrifying (Payne, 2012). Jungbauer et al. add that spouses whose partners are diagnosed with schizophrenia
maintain that the first experience of the symptoms of schizophrenia was overwhelming and they felt helpless and frightened as they did not understand what was happening to their partners. A study by Katalova-O’Doherty, Doherty, and Walsh (2006) reports that the initial encounter with schizophrenia was characterised by confusion and denial. In the case where the symptoms were gradual, the above study found that family members were not able to notice the presence of any psychopathology; however, the onset of schizophrenia caused disruptions in family life.

At times the severity of the illness dictates that the person be admitted to hospital in order to contain them. Jungbauer et al. (2004) mention that the process of admission is traumatic for most family members because more often the patient has to be immobilised, either physically or through sedation. Some of the challenges during the initial encounter with schizophrenia was accepting that their beloved has schizophrenia and Katalova-O’Doherty et al. argue that parents found it more difficult to accept that their children have schizophrenia. Lewin (1979) concede that the difficulties parents have in accepting that their child have schizophrenia has resulted in some of them believing that there is nothing wrong with their children and all that is needed is for them to get a job or pull themselves together. The compounding factor is as pointed out earlier that at times the symptoms are gradual and they seem less severe.

The current study’s participants experienced the same emotions when the illness first showed itself. Leseka relates how difficult it was to understand what was happening to his body. The illness initially presented with auditory hallucinations and his body felt foreign and weak. He had thoughts and ideas in his head which were terrifying. His wife Pumla, recounts the first day of his illness as the most puzzling. His hallucinations made him stay up all night because he was scared that he will succumb to the threats from the voices in his head.
Sindi’s symptoms were gradual and it was difficult for the mother to initially accept that her daughter might have schizophrenia. The daughter was initially cleared from any psychopathology by the psychiatrist and when ultimately a diagnosis of schizophrenia was made, the mother was ambivalent about the final diagnosis of schizophrenia. Her daughter’s first admission to a psychiatric hospital was distressing for her. She kept asking why the other professionals gave her daughter a clean bill of health. Thembi is aware that her daughter has been stable since taking medication for schizophrenia, however, it is difficult to fully accept the diagnosis. Thembi was raised by her paternal aunt because her mother was in a mental institution from 1958 till her death in 1997. She was hoping that her daughter does not end up like her mother in a mental institution; therefore, being faced with the reality that her own daughter had the same illness that took away her mother was daunting. For the daughter, her inability to discern what was real and not real was the most challenging. She says her inability to know that her paranoia was just in her head and not real and that people were not plotting against her was a source of extreme anxiety.

James presented with incomprehensible voices in his head which did not make any sense at all. He says that the only thing that made his thoughts quiet was to avoid noisy situations. It was puzzling in the beginning because he had no idea what was going on in his head. His sister was surprised at his quietness; he would isolate himself and never responded verbally to anyone. The sister cries when she recounts his behaviour; she was overwhelmed and helpless. This was the time when they sought help from the traditional healers.

**Explanatory Models**

The three families understood the cause of schizophrenia differently. There was no clear cut causes for the others. Since the beginning of time there has been thoughts regarding what causes mental illness. The following brief examination of mental illness shows how over the centuries and across different continents mental illness has been conceptualised.
Campbell (cited in Swanepoel, 2009) describes the pre-historic view of mental illness as being due to a breakdown in magico-religious systems. Lefkowitz and Fant (2005) mentions the Ancient World’s understanding of mental illness as being due to imbalances of the body fluids. In the Far East, the heart is perceived as the source of emotional and cognitive activities; therefore abnormal emotions are said to emanate from the heart (Haque, 2008). The Arabs maintain that ancestral influences, the evil spirit and the wrath of god contribute towards mental ill health (Swanepoel, 2009). In Africa, causation of mental illness is related to traditional religious beliefs; there is a continuity between the living and the dead and once the body has disintegrated through death, the spirit lives on and plays a significant role in maintaining health of the living (Patel, 1995). The New Testament claims that madness is caused by demons, the evil spirit and curses (Thielman, 2009). The current medical model on the other hand is of the opinion that genetic abnormalities, abnormalities in the brain and chemical imbalances are amongst the many causes of schizophrenia. From the above discussion, it is evident that the more things change, the more they stay the same.

In this study, the participants’ view of causation of schizophrenia spans the entire eras and different continents. Thembi had two different reasons for her daughter’s mental illness. The amount of stress that she was experiencing at the time of onset of the symptoms contributed to her illness. This is consistent with the Far East explanation of mental illness which states that difficulties of the heart result in abnormal emotions. The second cause is related to the ancestral involvement; she believes that her ancestors are directly responsible for her daughter’s illness. This is consistent with the magico-religious systems breakdown that was seen as being responsible for mental illness during the pre-historic era. Sindi on the other hand initially thought that she was bewitched. She consulted a traditional doctor who told her that her illness was caused by malevolent individuals who sent a monkey to her; that monkey was causing her delusions. Later, after she was admitted to the psychiatric hospital
and the anti-psychotics that she received reduced her symptoms, she concurred with her mother that stress was the main cause of her illness.

The family which was most religious, Pumla’s family, attributed the cause of his mental illness as the evil spirit. Thielman (2009) argues that Biblical explanation of ‘madness’ is that the evil spirit, demons and curses are responsible for the illness. Pumla took her husband to the church and according to her, the evil spirit was exorcized. She is convinced that his colleagues were jealous of him and they sent the evil spirit to destroy him. The other possible cause for Leseka’s illness was stress. The wife and the husband agreed that the severe financial stressors that he experienced before the beginning of his illness played a major role in the onset of his mental illness.

James’ family believed that the amount of noise that he was exposed to at his workplace caused his mental illness. This family is the only one that was not particularly religious or traditional. The sister attended church regularly and was a member of the prayer group but it did not seem like she has internalised the religious faith. The brother has not been to church in a while, however, he has a church that he belongs to. This does not in any way mean that their thinking about the cause of mental illness is related to their religiosity. This is an observation that is made; it could be unrelated to their perceptions. All three participants believe that the only help for schizophrenia is medication from the Western doctors.
Naming Things

What’s Montague? It is nor hand, nor foot,

Nor arm, nor face, nor any other part

Belonging to a man. O, be some other name!

What’s in a name? That which we call a rose

By any other name would smell as sweet;

So Romeo would, were he not Romeo call’d,

The above except is from Shakespeare’s Romeo and Juliet. Juliet argues that a name is just a name and it has no bearing on the qualities that its owner possess. We know from an African point of view that names are not just names, they are important. There is a saying in SeTwsana that says; *leina lebe seromo*; this is loosely translated as a bad name is like an itchy rash. There is another saying that says: *leina lebe leile boreelong*; this means that one with a bad name is behaving as badly as his name.

The use of the name schizophrenia has been argued by researchers, patients, families and clinicians (Tranulis, Lecomte, El-Khoury, Lavarenne & Brodeur-Cote, 2013). According to Sato (2006) the name schizophrenia was changed to Integration Dysregulation Syndrome as a reaction from patients and families as an attempt to curb the misunderstanding and the prejudices around the name schizophrenia. Sato reports that the name change and more information regarding the illness to the public resulted in reduced stigma. In the Netherlands, the Anoikis think tank started a competition where families and patients were asked to come up with a new name for schizophrenia (George 2010). Names that emerged from the competition ranged from: Bleuler Syndrome in memory of Eugene Bleuler who coined the name schizophrenia; altered reality syndrome; Sensitive mind syndrome and the
dysfunctional perception syndrome. George and Klijn (2013) adds that the schizophrenia labelling hinders self-acceptance and stands in the way of healthy self-regard. George and Klijn further argue that schizophrenia is an outdated name that does not accurately describe the illness; the name schizophrenia means a split personality which is misleading as that is not what schizophrenia is.

How we name things or describe them is very important as it represents the meanings that we attach to those specific things. Therefore the way one uses language to explain certain concepts should be noted. The participants of this study gave different names to schizophrenia. Wachtenhauser (1986) points out Gadamer’s assertion that all thought is linguistic and although thinking cannot be reduced to language, it is inseparable from it. Heidegger adds that the hermeneutic function of language is to bring something to light (Palmer, 1969). According to Gadamer (Palmer, 1969) language discloses our world and has the ability of laying open a space where the world can disclose itself. Therefore, what these participants named their illness indicates the meanings they attach to the illness.

Leseka names his illness depression. Even though the medication that he is getting at the clinic is for schizophrenia, he says that he has depression. His wife states that at some point during his illness, he had was seemed like negative symptoms of schizophrenia. His motivation was low and he spent weeks in bed. I did not question why he says he has depression because I felt that it is important for him to know that his illness is depression and that is the meaning that he attaches to his illness. His wife on the other hand, tried to pronounce schizophrenia and said that is what the doctors in hospital called his illness. James says his illness is “bolwete ba mantswe” (the hearing of voices illness). He feels that another way of making the voices less severe is to make sure that one avoids noisy spaces. It is very interesting to note that his family of origin seems to be very outspoken and there were
high levels of negative expressed emotions from his father. His father apparently is belligerent and that is one of the issues that James have with his father. The illness seem to be a metaphor to the relentless voices coming from his father. The name that the sister gives to schizophrenia is similar to James’.

Sindi calls schizophrenia being negative. She prefers to call it being negative even though she is aware that it is called schizophrenia. Of all the participants, she seems to have a lot of negative things that happened to her. Firstly, her lover rejected her and her child. That seemed to have precipitated the unravelling of her life. Her mother feels that that rejection contributed hugely to the onset of schizophrenia. Secondly, just before her first psychotic breakdown, she was working at a place where she was severely demeaned by her colleagues; they passed demeaning racial comments towards her. Lastly, when her family was going through financial difficulties, her younger sister took over and saved the family. Her role as the older sister was taken by the younger sibling. Therefore, she has a lot of reasons to be negative. Her mother on the other hand says that schizophrenia is the disease of the mind. She says that we are not born with the same minds and some of us have weak minds which cannot deal with stressors especially if we keep things bottled up.

This thesis reveals that the concept of Mafununyana has different connotations. Mafununyana is described by Niehaus et al. (2004) as a culture-bound syndrome where the person speaks in a muffled and strange voice and their behaviour is strange and unpredictable. Asmal et al. (2011) argue that this condition is used as a socially accepted explanatory model for containing inner turmoil. According to Scott and Browne (cited in Mkize, 1998) this condition affects mostly women over the age of 13 years and cuts across all religious, educational and occupational groups. Some of the symptoms are (Cumes, 1995) weeping, tearing off clothes, aggressiveness and self-injurious behaviour. Neppe and Tucker
(cited in Mkize, 1998) add that it may be difficult to differentiate Mafufunyana from schizophrenia as it is also characterised by delusions and hallucinations. Watts (cited in Cumes, 1995) argues that the syndrome reached epidemic proportions in the 1920’s and 1930’s and (Lee, cited in Cumes) it is assumed to have been due to acculturative stresses. Sindi mentions that the priest from the church and the traditional healer that she consulted told her that she has Mafufunyana. She recounts her earlier symptoms as characterised by intense paranoia and she often thought of hurting other people as she perceived them as dangerous to her. Her child was taken away from her because at times she believed that her daughter was responsible for her messed up life.

Leseka vehemently denied that he has Mafufunyana; however he acknowledged that her sister was diagnosed with Mafufunyana. He insisted that his condition was depression. The other male participant also states that the traditional healer with whom he consulted with told him that he had Mafufunyana. This is interesting because literature states that Mafufunyana presents in females mostly. However, it is popular belief amongst people staying around Soshanguve that Mafufunyana is a vernacular name for madness. That perhaps explains why the one participant felt that he does not have Mafufunyana. The importance of naming things and the significance of language is apparent in how these individuals explain and name their illnesses. Therefore, the everyday-taken-for-granted nuances can easily be missed if one does not listen to what is said.

Challenges

Changing roles

Literature argues that roles are redefined in the family when one member is diagnosed with schizophrenia. Jungbauer et al. (2004) state that spouses whose partners are diagnosed with schizophrenia have to perform roles which were previously performed by the ill spouse;
women found themselves forced to take over male roles of providing for the family and other
male oriented roles. This is consistent with what Pumla felt; she had to be the head of the
family and make decisions which were usually made by her husband before he fell ill. The
husband’s illness affected his judgment and this resulted in severe financial implications.
Pumla had to take over the finances and initially it was difficult for her because previously
that was her husband’s responsibility.

Östman and Björkman (2013) mentions that the role of the ill spouse as a sexual
partner changes. Their study found that there were spouses who had adjust to marriages
without intimacy for years because the illness and the medication affected their partner’s
sexual performance. The one spouse in the current study (Pumla) struggled to cope with the
changed dynamics in their sexual life. She mentions lack of intimacy in their marriage as the
biggest challenge she had to deal with; however, she is appreciative of the fact that the few
times that they were able to be intimate, they managed to bear children.

Sindi lost her position as the older daughter due to her illness. She was previously
held in high regard by her family because she was the most educated and had a good job;
however, when she fell ill her younger sister fulfilled that role. According to Schulze and
Angermeyer (2003) people diagnosed with schizophrenia feel that they are not taken
seriously because of their illness. The two participants in this study, Sindi and James, feel that
they are being disregarded in their families and the community because they have a mental
illness. Pumla feels that her family as a whole is not regarded by the community of because
of her husband’s illness. Sindi is convinced that if she was not diagnosed with schizophrenia,
she would have been far career wise; her mother, Thembi also echoes this sentiment. Thembi
believes that Sindi had a lot going for her before the illness. Stalberg et al. (2004) add that
individuals with schizophrenia feel that they have stagnated and their progress in life have be
stunted by their illness. Torrey (1980) argues that schizophrenia is an illness that destroys ambitions, hopes and potentials of early years and replaces them with broken thoughts, stunted and inappropriate emotions.

Some adults who are diagnosed with schizophrenia are denied the opportunity to be autonomous and responsible beings as they find themselves been taken care of by their parents, siblings or parents. According to Lefley and Johnson (1990) parents whose children are diagnosed with schizophrenia are responsible for their care and they may become long term carers. In this study, we have a sibling who has taken over the care of the older brother and it seems that the role will be long term. A wife has been taking care of her ill husband and she feels that even though the symptoms have abated with medication, she still responsible for his well-being. A mother of an ill daughter had to be both a mother and grandmother to her daughter’s child because she was unable to parent her child due to her illness. All three participants who are ill, are been taken care of by their family members, one way or the other.

According to Gerace et al. (1993) siblings perceive growing up in a family where there is a sibling with schizophrenia to have a debilitating effect on their lives; for these siblings schizophrenia causes a pervasive change in their lives. One of the participant from the study by the above authors equates his family to a warzone where one has to constantly dodge the missiles thrown into the family system by schizophrenia. The sibling in this study was overwhelmed by all that was happening in her family. She was forced to abandon her future plans and the possibility of getting married because she had to take care of her ill brother. Since her brother’s illness, her life has changed drastically. She has to be a parent to her brother now since there is no one else who is willing to take care or help take care of her brother. Her family was isolated from the community as neighbours were reluctant to come
and visit their family home because there was always yelling between her brother and her father. Schizophrenia disconnected her and her family from others.

**Stigma**

All the participants in this study experienced stigma since the diagnosis of schizophrenia. Literature define stigma as a socio-cultural process whereby the marginalised group is seen by others as abnormal, shameful or undesirable (Michaels et al., 2012). Watson et al. (2007) add that some people internalise the stigma and this results in reduced self-esteem and self-efficacy. Michaels et al.warns that even though some patients self-stigmatise, not everyone who is diagnosed with schizophrenia will self-stigmatise. For the participants in this study, it is significant how others perceive them. Sindi feels that people will treat you differently once they know that you have a schizophrenia diagnosis. Her concern was mainly towards people who know her; she feels that they will change their view of her. She feels comfortable talking about her illness with strangers. Even though it seems like she is self-stigmatising, her decision to keep her illness a secret is based on the comments that she has heard from other people who did not know that she has schizophrenia. Her perception of stigma includes members of her family. She feels her opinion at home does not count anymore because her parents and siblings think that having schizophrenia affects your thinking and reasoning.

According to Cumes (1995) teasing of psychotic individuals is seen by some as socially accepted whilst others feel that it is cruel to do so. James was teased relentlessly by the youth in his community during the earlier stages of his illness; they told him he belongs to a mental institution because he is mad. This mocking made him feel that his rights as an adult and a human being were violated.
Some of the stigma towards people diagnosed with schizophrenia is based on the myths that the public has about these people. Schulze and Angermeyer (2003) maintain that the perception by the public that patients with schizophrenia are violent and dangerous adds to the stigma. A South African news website News24 (2014) published a story about a man who in 1999 bludgeoned to death his parents, grandmother and a friend to death. The man got a prison sentence and at the time the district surgeon stated that the man had a drug-induced schizophrenia. This man was released on parole this year and he severely assaulted his wife. This is one of the comments made: “why was this nutter out on the streets again, there are enough out there that haven’t been caught”. In France this year, a woman stabbed a school teacher to death and she was said to have been suffering from a mental illness; the comments made about the incidents were similar. Berkowicz and Myers (2013) note that three of the deadliest American school shootings were committed by people who are mentally ill. Coultier (2013) also mentioned that guns don’t kill people, the mentally ill do. So all this sensational media reports about the mentally ill fuel the stigma prejudice against the mentally ill. When James needed hospital admission because he was floridly psychotic, the police were called to help get him to the hospital. The sister recounts the amount of force that was used to get him cooperate. She was really upset because she knew that her brother would not harm anyone; however, the fear the police had made them use unnecessary and excessive force. Sadock and Sadock (2003) add that patients with schizophrenia are no more likely to commit homicide than the general population; this is in spite of the sensational media attention when someone who is diagnosed with schizophrenia murders someone.

Phelan et al. (1998) suggest there are certain social characteristics of the family and the patient which contribute towards the level of stigma that is perceived by these families and patients. People with college degree concealed their illness more than those without college degrees. Sindi, who concealed her illness more than the others in this study has a Law
degree and is high functioning. She does not want to be treated as an invalid; she believes that she is not her illness. Schizophrenia is something that happened to her like asthma or hypertension happens to someone.

People diagnosed with schizophrenia struggle to integrate their inner self, which contributes towards their social identity (Brady & McCain, 2004). Estroff (1989) calls schizophrenia an ‘I am illness’ because it overtakes the individual’s personhood and redefines ones identity. Participants in this study feel that since their illness, they are being treated differently by their families and the community, it is as if they do not exist. Whatever they say does not matter and that is one of the main challenge that they are grappling with since their illness. One family in this study felt that the neighbours ostracised their family because of the husband’s illness. Even though there are people who state that you are not your illness, stories of individuals with schizophrenia show that the illness does change the self (Estroff, 1989).

James yearned for his father’s understanding and support. The illness made it difficult for him to have a decent relationship with his father; they fought all the time and his father disowned him after the last major fight they had. He did not exist anymore in his father’s eyes and that hurt him a lot. Even today the father refuses to acknowledge that his behaviour was as a result of an illness.

Fox (2004) relates how her illness took over her ability to parent her children. She was deemed an unfit mother and she was judged differently, she was looked at curiously and she felt that she lost the unconditional respect that she had before she fell ill. Being able to be a parent is very important for Sindi. Since being ill she was forced to hand over her parenting duty to her mother. One of the major challenges for Sindi is that she wants to have more children but she is fearful that her child might be born with a mental dysfunction. The illness
took away that fundamental right of being a mother. Her existence as a woman with a potential of being a mother is blurred. Pumla, whose husband has schizophrenia, felt that their family was not acknowledged anymore because of her husband’s illness. All this family wants is to be acknowledged that it exists.

**Coping mechanisms**

*Out of suffering have emerged the strongest souls; the most massive characteristics are seared with scars.*

Khalil Gibran

Hefti (2011) reports that people with intrinsic religious orientation who have internalised their belief experience lower levels of depression. One participant states that her husband’s illness was very stressful, especially in the beginning of the illness when his odd behaviour was more pronounced. However, she found that the Bible and knowing that God is always with her family, made it easier for her to carry on. She mentions that she never had the need to consult psychologists or seek psychotherapy because of her faith in God was comforting. This is consistent with what Mkhize (2012) argues that in South Africa the vast majority of the population cannot afford psychologists/psychiatrists and even if they could, there is evidence that they would still prefer healing services that are in line with their indigenous models of health/illness and explanatory models.

Parents of individuals diagnosed with schizophrenia are known to use the downward social comparison strategy to cope with their children’s illness (Knudson & Coyle, 2002). These parents cope well with their children’s illness if their illness is not so severe and their functioning is higher. Of all the participants in the current study, Thembi used this strategy to cope. She felt relieved that her daughter’s condition is not so bad and that she is responding better to treatment as compared to other people with the illness.
Gerace et al. (1993) point out that a collaborative approach has been reported to be useful as a coping mechanism for siblings who have a sibling diagnosed with schizophrenia. This approach is a strategy where the sibling, the parent and mental health professionals work together in caring for the ill sibling. Mary uses all the available resources and support to help her cope with James’ illness. She involved the social workers to help resolve some of the challenges that ensued from her brother’s illness. This, according to Gerace et al. offers a reprieve for the main carer.

Kinsella et al. (1996) suggest an alternative strategy which is called constructive escape where carers take care of themselves by leaving the home environment. All three participants in this study used this strategy to reduce the load of caring. Pumla spend a lot of time in church performing church activities; she also used prayer to emotionally escape the environment at home. Mary took part in weekly prayer meetings at church and talking to the other women seemed to alleviate her burden. Thembi immersed herself in her work; she works seven days a week including holidays. Being around people is helpful for her and she is very open to others, even strangers, when she is stressed out.

Jensen and Allen (1994) discuss five steps of coping with mental illness as: *comprehending*; all the participants in the current study strove to get an understanding of what schizophrenia is. Thembi was numb in the beginning but she tried to assimilate all the information that the psychiatrist gave her about schizophrenia and how it presents differently in different people. She felt more in control once she understood what the illness is and is not. For Pumla the term schizophrenia was so strange and it took her time to make sense what kind of illness it is. She remembers being told that her husband’s brain is damaged.

The second stage is *managing*; all the participants had to manage and adjust to the changed life. They have to find ways of dealing with the changed self. All the family
members had to be carers instead of being wives, mothers and sisters of grown individuals. The ones with schizophrenia had to accept the new themselves. They had to make peace with the lost opportunities and learn to redefine their new identities as people with schizophrenia. Sindi had a successful career and earned a good salary; she had to be okay with getting financial assistance from her younger sister and make do with the disability grant that she is currently getting from the government. Leseka had to give over his role as bread winner to his wife. He became one of the children. Before his illness, James played an important role as the carer of his siblings; now he is the one cared for and he has to adapt to this new role.

The third stage is **belonging**: families had to find ways of connecting to each other and the community. For others it was easier to connect and belong than the others. Sindi and James’ families are still struggling to find that connectedness; however there are other areas where it is easier for them to make connections, like the church.

The fourth stage is **normalising**: after dealing with the previous three stages, the participants reached a point where they felt that they need to carry on living in spite of schizophrenia. It was easier for these participants to get to this point because the severe symptoms that were apparent in the early stages of the illness have abated. Their families also feel that life is as good as it can get for them and their ill relative. Having schizophrenia has also enabled these families to identify their strengths and the illness is seen as a potential gift instead of being this dark cloud that has befallen them.

Lastly, **valuing**: family members feel that there is hope for their ill relative. It has been challenging and difficult but they have been able to transcend the hurdles that come with having someone with a schizophrenia diagnosis in the family. The ones with the illness have their hopes as well. Sindi is hoping to finish her Law degree and practice as an attorney; Leseka hopes to be able to go back to work and provide for his family; and James hopes that
the relationship with his father that was tarnished by the illness will be restored and he will be able to take care of his siblings and father. The following section discusses positive outcomes of being diagnosed with schizophrenia.

**The Gift of Schizophrenia**

There were some positives that came out being diagnosed with schizophrenia or having a family with a schizophrenia diagnosis. A sibling in Kinsella et al. (1996) study commented on the personal growth that he experienced from having a sibling with schizophrenia. All the participants of this study learned to focus on the positives in their lives instead of the illness and its limitation. Sindi is grateful of what the illness has offered her. She sees herself as having different and meaningful experiences from her illness. She has learned to acknowledge her strengths and weaknesses. Her mother says that her daughter’s illness taught her not to sweat the small stuff; she quoted a Biblical scripture that claims that God will provide for us as He has provided for birds.

Mannion (1996) mentions the personal growth that occurs when one has a family diagnosed with schizophrenia. Parents’ roles are amplified and this brings closeness and strengthens the relationships between parents and their ill children. James’ mother had an intense closeness with her son; she was the quintessential nurturer and carer; she was always available to care for James. Mannion suggest that spouses experience increased empathy and this enhances their humility and improves their spirituality. For Pumla, Leseka’s illness made her more appreciative of the taken-for-granted things that Leseka was able to achieve. For example being able to attend school meetings was seen as a great achievement.

Addo (2002) argues that God cannot be directly approached by mere mortal and that ancestors are the mediators between God and the living humans. Thembi learned to reconnect to her ancestors because of the illness that befell her family; she perceives herself as a
Christian but she believed that talking to her ancestors and ask seeking help from them was appropriate. Thembi also learned to connect to others and not to keep everything to herself.

Gockel (2009) state that spiritually is a meaning system which guides our perception and experiences. Huguelot and Mohr (2009) add that region offers self-development which instils meaning, purpose and hope in the lives of people. In this study, all the participants redefined the illness and instead of seeing it as something which is all bad, it was seen as a gift. Pumla found it easier to fast for prolonged periods of time and this kept her closer to God and her spiritual life flourished.

McCann and Clark (2004) found that spiritual activities were uplifting and provided social contact to most people who had serious mental illness. Families and patients in this study appreciate the connections that they have with their church. The challenge of schizophrenia enabled them to be part of the large church community. Of all the three families in this study, one family (James’) experienced an overwhelming support and connection from the community and this family is treated as family by the community. The spirit of Ubuntu is mirrored by the relationship that this family has with others around them. Yen and Wilbraham (2003) say that Ubuntu is the fundamental humanity and caring for the well-being of others. Mbiti (1969) adds that the individual cannot exist alone and he owes his existence to other people.

The stigma that one of the families experienced (Leseka and Pumla’s), resulted in this family avoidance to connecting with other people. This family spend time together all the time; they closeness to each other was comforting. Literature has revealed that most families avoid social contacts and that is stressful for them as they feel isolated (Anonymous, 1994) Leseka’s family redefined the isolation and loneliness as something that is beneficial to their
family. It is evident that both connections and disconnections that these families experienced as a result of schizophrenia, played significant positive roles for these families.

Summary

This chapter integrated the findings of this thesis with available literature. The everyday taken-for-granted struggles that families and patients who are diagnosed with schizophrenia have are revealed. From the above discussion it is observed that there are things that have been lost and gained through the diagnosis of schizophrenia. The most fundamental gains are the personal growths of those diagnosed with schizophrenia and the family members. Schizophrenia was a gift as it allowed people to be aware of their strengths and coping mechanisms. There are connections made which might not have developed to the levels that they have. What stood out was the dignity and the pride these patients presented themselves with. It is also evident that one cannot assume that culture will remain stagnant; it evolves and moves with the times. It is also evident that traditional beliefs are not static and people adopt health practices that make sense to them. The next chapter is the final section of this thesis and it starts with the beginning of the journey and ends with the final thoughts.
Chapter 14

Conclusion

This final chapter presents my reflections of this journey. Based on the outcome of this study, recommendations for practice will also be presented. It is regarded as proper practice in research circles to examine the limitations of the study; however, I will not be discussing limitations as I believe that this study accomplished what it set out to do, which was to explore the experiences and understandings of schizophrenia by patients diagnosed with the illness. Secondly, the study sought to explore how these understandings and experiences emerged from a Black cultural point of view. Future research suggestions will also be presented.

My Reflections

Entering the Arena

I would like to begin my reflections on the journey with the process that unfolded earlier on during this study. My supervisor’s enthusiasm for the topic made it effortless for me to face all the obstacles that any PhD student encounters.

Perusing the literature on this topic was overwhelming because of the vast volumes of literature available. It has been shown in the literature, especially from personal account articles, that the symptoms of schizophrenia are overwhelming for patient and family alike. The immense scope of the available literature was like a metaphor for the illness: one had to sift through all of it and take out what made sense at the time. In the same way, the person with schizophrenia is bombarded with perceptual messages which at times are senseless but which, when sifted carefully and looked at in context, acquire meaning.
My pre-understandings were discussed comprehensively in the method chapter. It was evident from that discussion that I had certain personal experiences of mental illness based on my family’s beliefs about psychotic mental illness. I had to keep that in mind during the interviews, as I did not want my experiences to direct the flow of the conversations. I kept a curious stance and I wanted the participants to lay bare what they understood about the illness and how it was for them.

People diagnosed with schizophrenia have a tendency to be tangential, and the conversations may take a route away from the focus of the story. However, I had the most amazing experiences imaginable with the six participants. All six participants were master story tellers and I was always amazed at how beautifully they presented their stories. Some were more eloquent and verbose than others; however, the ones with less to say also said a great deal. Their silences and long pauses imparted so much information. They did not always have to put words to what they were feeling; it was felt in the room and acknowledged.

Throughout the whole process of the interviews I had a mental image of someone walking through a forest not knowing what they are going to come across. Surprises came out of the bushes at every turn, and that fuelled my curiosity. I am a clinical psychologist and I can confidently say that I have listening skills; however, this process taught me how to really listen. Heidegger argues that listening is a silence that is pondering (Johnson, 2000). This means that the listener should hold back their conceptual pre-understandings in order to ponder words that present themselves in the text. Heidegger further adds that this is the type of listening that creates a space for the emergence of what has been concealed. The more I waited and listened, the more I gained a better understanding of what was being said; the phenomenon was revealed. Palmer (1969) argues that, from a hermeneutical point of view,
being able to hear what the text did not say is the core of the hermeneutic task. The following quotation (Palmer, 1969, p. 234) sums up this assertion: “It takes a great listener to hear what is actually said; a greater one to hear what was not said but what comes to light in the speaking”.

There were times when I thought the story was going off course, but I just remained there, listening and waiting for whatever it was that needed to be revealed to eventually reveal itself. Heidegger calls this the clearing that one gets to.

I asked one lady to tell me how her culture informed her understanding of the illness. Her answer was spell-binding. She told me about the paths that she had walked while going to school during her pre-adolescent years. She narrated the challenges of growing up without financial resources and said how hungry she had got. This lady had a friend whose family was financially better off than her family, and this friend used to share her lunch money with her. Unfortunately for her, the friend left school and she then went hungry most of the time because she had no money for lunch. She started picking up pennies lying on the path she used to take to school. Her question was: Who had put those pennies there for her to pick up? She was raised by her paternal aunt and they never consulted traditional healers; instead they believed that one needed to pray for guidance and healing. Each time she picked up pennies, she wondered who was providing her with money for lunch. Her answer to my question was that there are unexplained things that are responsible for events in our lives. She believes that the dead are never dead.

There were other instances during my encounters with the participants that left me extremely respectful of the way language is used and mindful of the importance of paying attention to what is not said in order to reveal what is meant. When listening to the stories, I realised that I could have spent more time at a particular point in the journey; I could have
spent more time in the forest to take in the beauty and the pain that were part of the landscape. I left the forest as a different person, one who has more understanding of schizophrenia. The following section explains of what this thesis revealed.

**Coming full circle**

This thesis revealed the taken-for granted experiences of those diagnosed with schizophrenia and those who have to live with someone diagnosed with the illness. All three families showed a tremendous amount of resilience, and the illness was not allowed to take control of their lives. The dynamics that played out in these families revealed the levels of adjustment that had to occur in order to make sure that the family as a system did not disintegrate.

The boundaries that were created by the different families were consistent with the structures of that specific family. It is noted that some families had to make the boundaries more rigid for self-preservation. The families where there were rigid boundaries felt that the integrity of the family system was threatened. The amount of information that got out of the family system to the bigger communal system about the presence of schizophrenia in their family was dependent on what they felt was appropriate. The degree of rigidity of the boundaries was also dependent on what they perceived was beneficial for the system. For instance, it was appropriate to engage with strangers about schizophrenia as they thought strangers would not be likely to judge them. This in turn limited the connections that the family system made.

For some families, secrets formed part of the family functioning. Keeping secrets within the family and outside of the family allowed this family to remain whole and functional; this led to the formation of intra-familial boundaries. Some families maintained rigid boundaries within themselves, which means that those diagnosed with schizophrenia
were not indiscriminately free to engage their family members about their illness. It was not only the families that erected these boundaries; sometimes the community also put up boundaries that kept these families out. This was seen in the level of stigma that some of these families experienced from their communities.

The other dynamics that were apparent in these families was the ability to adjust to the change in family structure. Wives took over the roles of their husbands; sisters became mothers; mothers mothered their children’s offspring; older brothers lost their positions of authority and became their sister’s children; grown-up daughters became infants who needed mothering; fathers became one of the children. The above changes elicited so much growth for the families and their ill relative. Those with the diagnosis of schizophrenia adjusted to all these changes with dignity and courage. The family members also took over the new responsibility with unconditional love and a hopeful spirit. Above all, families learnt self-reliance. Order emerged out of the chaos of schizophrenia.

A severe and debilitating illness like schizophrenia has the potential to destroy one’s sense of identity and being. For these family members the narrative from the public about the illness is that “you are different from us.” One of the families was made to feel like outcasts because of the lack of understanding from the community and the judgments that were thrown at them. The identity of this family changed. The children had to learn that their family is different from other families: Dad is not doing what other dads do and Mom represents both parents.

Another family had been held in high esteem before the daughter became ill. Things fell apart for this family. The daughter had to move to a different area as she felt that the neighbours might notice that she was not well.
For the individual with a schizophrenia diagnosis the dominant narrative received from others is: “I am mad and bad.” Some literature and the media argue that mentally ill people are not to be trusted as they are inherently violent. The challenge is to make people understand that schizophrenia is not an identity; it is just a diagnosis like any other diagnosis. The role that one played in the community as a respected and worthy citizen has changed. People in the neighbourhood are not always sure how to relate to those diagnosed with schizophrenia as they are scared that they might act violently.

The other narrative is “I am lazy.” One of the negative symptoms of schizophrenia is low motivation or psychomotor retardation and disorganised behaviour. Someone who is not informed about the illness may think that not bathing; not changing clothes and staying in one place for hours on end is because of laziness. One of the participants experienced this especially at work.

“It is my fault.” Sometimes when things do not make sense, blaming, either oneself or others, is a way of making sense of one’s circumstances. Some of these participants feel that if they had not had so much debt, they might not have had the illness; if they had not worried so much about things that went wrong in their lives they might be ‘normal’ now. The blame was also directed towards some of the carers. Families blamed each other for the illness; ancestors were blamed for allowing the illness to occur.

“I am useless” This feeling was either based on real input from family or community members, or simply imagined. The community and some family members disregarded the opinions of the ill relative.

Regardless of the challenges relating to the changed identity as a result of schizophrenia, all the participants decided to reclaim their place in community. Having
schizophrenia did not obliterate the hopes they had for their lives. Some still hope to be able to have children irrespective of the fear that having schizophrenia means their offspring might inherit the illness from them. Some hope to be able to take care of their families. Some hope to go back to work and provide. Others hope that they may be able to resuscitate their careers and become financially independent. For the families, their hope is for total healing.

They hope that their ill relatives might gain financial independence and take care of themselves. There is a hope that things might go back to where they were before the illness; intimate relationships will be revived. The hope that all these participants have seems to be what keeps them going.

**Meeting of the cultures**

Culture seems to have played a crucial role in how these participants dealt with the illness, especially in the beginning. They all sought help from non-Western doctors when the illness emerged. Even though they did not persist with the traditional treatment for schizophrenia, the process of first consulting the traditional healers had important meanings for them. It is understood that when Africans get a severe illness, they try to understand causation from the ancestral point of view. Rituals and libations were performed by some of the families in an attempt to appease or find answers from the ancestors. Prayer and other rituals were performed by the Christian and the African traditional churches. It has been evident in this thesis that cultural beliefs change with time and people will seek and practise activities that make sense to them. Heraclitus’ famous saying that one “cannot step in the same river twice” captures the notion that our experiences and beliefs change every day. This means that we are different people at different points in our lives. I am certain that if the same participants were to tell their stories now, their stories would be different. However, it should be noted that the stories of these participants revealed their experiences at that time.
Soshanguve is an urban township, and the people residing there are at different stages of urbanisation. Muzorewa (1985) states that there is a tendency for Africans to combine African traditional beliefs with Christian beliefs. This practice, which is called syncretism, is viewed positively by some as it is a way of reconciling African traditional beliefs and modernity. This is consistent with what Wanamaker (1997) says about ancestral worship practices that have to adapt to social and economic changes. According to Hunter (1961), urbanisation resulted in changes in the ways Black Africans perform their traditional ritual practices. Swartz’s (1998) assertion that there is an overlap between different healing practices and beliefs among South African Blacks is borne out in this study.

**Fusion of the different horizons**

According to Marshall (2004), in a conversation where understanding occurs, each person brings a horizon, which is a “range of vision that includes everything that can be seen from a particular vantage point” (p. 125). Gadamer describes fusion of horizons (horizontverschmelzung) as the process that occurs when the interpreter’s horizon is not his point of view but a possible opinion that comes into play. It is a conversation that does not belong to either the interpreter or the author of the text (Rorty, 2004). Marshall further maintains that horizons are not static or fixed; they move and change with the individual and cultural life. I have stated my horizons about psychosis in the method chapter. Before undertaking this study, my horizon or the vantage point that informed my understanding of psychotic mental illness was that cultural and traditional beliefs of Black South Africans influenced the treatment modality that is chosen. Literature revealed that there are certain psychotic conditions where practices like *thwasa* will restore the person’s mental health. The horizons of the participants in this study are: ancestors are responsible for schizophrenia, therefore an appeal should be made to them in order to alleviate the symptoms; the evil spirit is responsible for the emergence of schizophrenia, therefore one needs to pray and ask
healing from God; there are environmental factors like noise that cause schizophrenia; therefore it is crucial to avoid noisy places.

I have a different understanding of schizophrenia from a Black South African point of view. I understand that the meaning one attaches to schizophrenia is based on the different spaces or circumstances that one finds oneself in when the illness occurs. I understand that one cannot take it for granted that all Black South Africans attribute the causation of schizophrenia to a specific entity. I understand that different treatment modalities are effective for different people. I understand that the effect of schizophrenia on the family and the individual is different; for some people keeping secrets is beneficial, and for others being open about their challenges offers comfort. The fusion of all these different horizons brought about a different understanding of the experiences and the meanings that are attached to schizophrenia by people who are diagnosed with schizophrenia. Bowie (2004) asserts that one can never say that one understands better and it is enough to say that one understands differently, if one understands at all.

**Suggestions for future studies**

Participants who took part in this study have been compliant with their medication since the diagnosis of schizophrenia was made. They have stated that the fact that the symptoms of schizophrenia were alleviated by medication from the hospital made it easier for them to decide which treatment modality to follow; however, some people default on their treatment. Currently the default rate at the clinic between January 2014 and July 2014 is 6.1%, and about 95% of these defaulters are those who have been diagnosed with schizophrenia. Therefore, a similar study focusing on those who default on their treatment is recommended. It would be interesting to find out what their thoughts are about schizophrenia and how they understand the illness from their traditional point of view. This might be useful in reducing
non-compliance or in better understanding these patients’ challenges with the medical model’s treatment of schizophrenia.

Implications for Practice

Significant insights emerged from this study. The implications this study has for mental health practice are examined in this section. Issues that seem pertinent are: psycho-education; stigma; family relations and support groups and the rotation of mental health nurses. Limitations of this study will also be examined.

Psycho-education

Firstly, it should be noted that, in the case of all these patients, their first experience with mental health professionals was positive. They were all satisfied with the explanation they got about the illness. However, there were certain important issues that were not discussed with the patients. This thesis revealed that there is a need for mental health care practitioners to respond to the patients’ concerns regarding what may seem like every day trivial complaints. For these patients these are significant challenges affecting their lives. Most felt that the side effects of the medications were not pointed out to them; even when they had complaints that seemed to be related to medication side effects like impotence and mild extra-pyramidal side effects, they were not given enough information in terms of what to do and where they might get help. For example, some literature has suggested that couple who have sexual difficulties due to the side effects of medications should be sent for couples’ therapy. The couple may learn different and alternative ways of being intimate instead of resigning themselves to a passionless union. Another issue that emerged from this thesis is procreation. Those patients who are still interested in having children should be given information regarding the heritability of schizophrenia and allow them to make informed decisions about their lives. An appeal should be made to mental health care professionals to
remain sensitive to the needs of patients getting treatment for schizophrenia and to create a space where they might feel comfortable to raise and discuss their concerns.

Staffing considerations

According to the Guidelines for the Integration of Mental Health into Primary Health Care (2008), mental health services should be integrated with general health services. The purpose of this integration is to provide standardised systems and procedures for the management of mental health-related problems at all levels of care. The benefits of integration are: early identification and management of mental disorders; reduction of stigma and ensuring a holistic approach to treatment of patients. This move towards integrating services at the clinics sounds like a feasible plan; however, the experiences of mental health care users indicate a need for stability and consistency regarding rotation of mental health nurses. Currently the clinic is adopting a rotation system for mental health care nurses. There are no designated mental health nurses; therefore, at the moment psychiatric nurses rotate every 12 months. This seems to have unintended consequences, as most mental health patients take time to develop rapport with health providers. Trust forms a significant part of the relationship between the patient and the health provider. One of the patients in this study who experienced sexual performance challenges felt that he had no recourse regarding the issue as he feels uncomfortable opening up to the different psychiatric nurses that have been allocated to the department. He discussed his problem with the nurse who worked at the mental health department four years ago but has not established enough rapport with the current ones to raise his challenges. The psychiatric nurse who is currently working at the clinic states that it took her about seven months to develop rapport with, and trust from, the patients. The suggestion emerging from this thesis is that staff rotation of mental health nurses in the clinic specifically, and throughout the country generally, should be reviewed.
and that consideration should possibly be given to prolonging the period of time that mental health nurses spend in one clinic before being rotated.

Family involvement

It emerged from this study that some healthy family members found it difficult to speak openly about schizophrenia with their ill relatives. This resulted in feelings of isolation on the part of the ill relative and guilt and discomfort in their family members. Mental health practitioners need to be aware of this issue and, as part of the follow-up reviews, identify the level of openness that families have towards schizophrenia and facilitate the discourse between family members and the patients.

External Support System

The effects of being diagnosed with schizophrenia were overwhelming for the family members and the patients in this study. A multi-disciplinary team approach would benefit these patients and their family members. The guidelines for the integration of mental health into primary health care (2008) describe the multi-disciplinary team as consisting of: psychiatric nurse, psychiatrist/registrar, psychologist, social worker and occupational therapist. Currently, the mental health team in the clinic comprises the psychiatric nurse, the psychologist and the psychiatrist. A need for the following practitioners was evident from the findings of this thesis:

Social workers

The primary health care package for South Africa (2001) states that all clinics should have access, by referral or periodic clinic visits, to psychiatrists, psychologists, social workers and occupational therapists. Currently there is no mental health social worker in the clinic. It is suggested that patients and families would benefit from the services of a social worker. This study revealed a need for this type of service. Some of the participants had social issues which needed intervention from the social worker. Currently, the patients or their families are sent to the Department of Social Services in the community for assistance.
**Occupational therapists**

Occupational therapists play a significant role in mental health. The Gauteng Department of Health advocates for rehabilitation and reintegration of mental health patients into the community. To attain this, skills training through a systematic skills building programme by means of psycho-education and cognitive behavioural interventions is suggested. Literature has revealed that low self-esteem and self-efficacy contributes towards self-stigmatisation. Occupational therapy might increase the repertoire of skills of people diagnosed with schizophrenia. Reducing self-stigma may improve the quality of life of those diagnosed with schizophrenia.

**Traditional health providers**

The primary health care package for South Africa (2001) has norms and standards which are to be adhered to. One of the standards is that staff should seek a collaborative association with local traditional healers. Currently, the clinic has a list of traditional healers, but the collaboration with these practitioners has not been effected. The role that traditional health providers play in mental health has been evident in this study. This includes traditional healers and African traditional church healers. All participants initially sought help from traditional or religious health practitioners. The role of these health providers will be to clarify psychotic mental illness from the traditional or spiritual point of view and offer counselling or expertise for those in need.

**Stigma**

Literature has revealed that a useful way of dispelling stigma is to use broadcasting as a means of disclosure, which means educating people about mental illness. Stigma emerged as a pertinent challenge for those who have been diagnosed with schizophrenia and their families. The following tools are suggested for this purpose:
- Use of media, such as videos in waiting areas at health care facilities and public spaces to give information about schizophrenia and other psychoses.
- Making pamphlets available for other patients in health facilities and other public spaces.
- Encouraging patients who have been diagnosed with schizophrenia, and who are willing and comfortable to share personal experience about it to share their experiences and in so doing to debunk myths about schizophrenia.
- Early education of school children about mental illness. Collaboration with the school health nurses and the Department of Education to raise mental health awareness in schools.

A study by Lund, Kleintjies and Mjadu et al. (2008) found that even though mentally ill people are still stigmatised, the level of stigma has declined. However, in Soshanguve, the above measures need to be amplified and applied constantly. Mental health psycho-education should not be in the spotlight during campaigns only.

**Support groups**

As part of the psycho-social rehabilitation programme for mental health care users, the Department of Health is advocating for community involvement in mental health. One of the strategies of this programme is the creation and maintenance of support groups for people with mental illness in the country. The focus of the support groups is on mental health patients and their caregivers. However, in Soshanguve Community Health Care Centre, families seem to be included only during the community mental awareness campaigns. There is currently no support group for the carers at Soshanguve Community Health Care Centre. One issue that came out of this study is the need for family members to connect with others who are in a similar position. Therefore, this thesis suggests the formation of a support group in the clinic for families who have a relative diagnosed with schizophrenia. This thesis
revealed that there were some families that felt comfortable sharing their experiences of schizophrenia in their families and others who felt judged by those without the experience of the illness. Support groups for the families will create a space where carers can share their challenges and coping strategies.

**Limitations of the study**

This study focused on patients and their family members who are getting treatment from Soshanguve Community Health Care Centre. Experiences of those who defaulted or those who decided not to take medication will most probably be different from the sample that took part in the study. Therefore, the findings of this thesis are most likely to resonate only with those who committed to the medical model treatment modality. The intention of this thesis is not to generalise the findings to the whole population of schizophrenia patients in Soshanguve, but to explore the experiences of those who took part in the study. Some of the participants’ stories may be similar to those of other patients who were not part of the study and some will differ.

**Last thoughts**

This section marks the end of the thesis which formed part of my studies towards a PhD. The process that took place entailed leaping from the known to the unknown. The known were my pre-understandings about psychotic mental illness and the unknown were the participants’ views and understandings of schizophrenia. I hope the findings of this thesis will give a voice to the voiceless. I also hope that these individuals will continue to teach us about schizophrenia and that we will stay attuned and sensitive, not only to what is said but to what is not said as well. It is my wish that the dignity and the composure that these patients and their family members presented themselves with regardless of the challenges of
schizophrenia should remain intact. I hope that these ‘invisible’ people claim their place in society and refuse to be put in boxes.
References


Mohr, S., Borras, L., Rieben, I., Betrisey, C., Gillieron, C., Brandt, P et al. (2010). Evolution of spirituality and religiousness in chronic schizophrenia and schizo-affective


**Unpublished South African Department of Health Guidelines**

Guidelines for the integration of mental health into primary health care (2008)

Primary healthcare package for South Africa (2001)

**Appendix 1 (Participant Consent Form in English)**

University of Limpopo (Medunsa Campus)
PARTICIPANT CONSENT FORM

Statement concerning participation in a Research Project.

Name of Study: Mental illness and the Black South African culture: Exploring beliefs and meanings attached to schizophrenia

I have read the information on the proposed study and heard the aims and objectives of the proposed study. I was provided the opportunity to ask questions and was given adequate time to rethink the issue. The aim and objectives of the study are sufficiently clear to me. I have not been pressurized to participate in any way.

I understand that participation in this study is completely voluntary and that I may withdraw from it at any time and without supplying reasons.

I know that this Study has been approved by the Research, Ethics and Publications Committee of Faculty of Medicine, University of Limpopo (Medunsa Campus) and the Department of Health. I am fully aware that the results of this Study will be used for scientific purposes and may be published. I agree to this, provided my privacy is guaranteed. I also agree to the use of an audio-tape to record the interviews.

I hereby give consent to participate in this Study.

........................................................................................................  ............................................................
Name of participant                                             Signature of participant

........................................................................................................
Place                          Date                          Witness

Statement by the Researcher

I provided verbal and written information regarding this Study.

I agree to answer any future questions concerning the Study as best as I am able.

I will adhere to the approved protocol.

Diana Monama ........................................  ...........................................
Name of Researcher                                             Signature                     Date                          Place
Appendix 1a (Participant Consent Form in SeTswana)

UNIVERSITY OF LIMPOPO (Medunsa Campus) SETSWANA CONSENT FORM

Seteitemente se se ka ga go tsaya karolo mo Tekopatlisisong / Porojeke ya Patlisiso*.

Leina la Porojeke / Patlisiso / Tekelelo*

Bolwestse ba tlhogo le setso sa batho batsho ba Afrika Borwa: Tshekatsheko ya maikutlo mabapi le bolwetse ba schizophrenia (mafongfonyane)

Ke buisitse tshedimosetso mo */ke utlwile maitlhomo le maikemisetso a* patlisiso e e tshintshintsweng mme ke filwe tšhonoy go botsa dipotso le go fiwa nako e e lekaneng ya go akanya gape ka ntlha e. Maitlhomo le maikemisetso a patlisiso e a tlhaloganyega setle. Ga ke a patelediwa ke ope ka tsela epe go tsaya karolo.

Ke tlhaloganya gore go tsaya karolo mo Tekopatlisisong e / Patlisiso / Porojeke* ke boithaopo le gore nka ikgogela morago mo go yona ka nako nngwe le nngwe kwa ntle ga go neela mabaka. Se ga se kitla se nna le seabe sepe mo kalafong ya me ya go le gale ya bolwetsi jo ke negang le jona e bile ga se kitla se nna le tlhotleletso epe mo tlhokomeleng e ke e amogelang mo ngakeng ya me ya go le gale.

Ke a itse gore Tekopatlisiso / Patlisiso / Porojeke* e e rebotswe ke Patlisiso le Molao wa Maithsholo ts Maiphase ya Medunsa (MREC), Yunibesithi ya Limpopo (Kampase ya Medunsa) / Bookelo jwa Ngaka George Mukhari. Ke itse ka botlalo gore dipholo ts Tekelelo / Patlisiso / Porojeke* di tla dirisetswa maba ka a saentifi e bile di ka nna ts aphasaladiwa.

Ke dumelana le seno, fa fela go netefadiwa gore se e tla nna khupamarama. Ke dumelana le tiriso ya segatisa mantswe (audi-tape) go gatisa poledisano ya me le mmatlisisi.

Fano ke neela tumelelo ya go tsaya karolo mo Tekelelong / Patlisiso / Porojeke* e.

........................................................................................................................................
Leina ka molwetse/moithaopi Tshaeno ya molwetse kgotsa motlamedi.
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Lefelo Letlha Paki

............................................................... ............................................................... ............................................................... ...............................................................
Seteitemente ka Mmatlisisi

Ke tlame tshedimosetsa ka molomo le/kgotsa e e kwadilweng malebana le Tekelelo / Patlisiso / Porojeke* e.

Ke dumela go araba dipotso dingwe le dingwe mo nakong e e tlang tse di amanang le Tekelelo / Patlisiso / Porojeke* ka moo nka kgonang ka teng.

Ke tla tshegetsa porotokolo e e rebotsweng.

Diana Monama ........................................................................................................................................
Leina la Mmatlisisi Tshaeno Letlha Lefelo

*Phimola sengwe le sengwe se se seng maleba.
MEDUNSA RESEARCH & ETHICS COMMITTEE

CLEARANCE CERTIFICATE

MEETING: 06/2013

PROJECT NUMBER: MREC/M/179/2013: PG

PROJECT:

Title: Mental illness and the Black South African culture: Exploring experiences and meaning attached to schizophrenia

Researcher: Ms D Monama
Supervisor: Prof W Basson
Department: Psychiatry, Clinical Psychology & Psychology
School: Medicine
Degree: PhD Psychology

DECISION OF THE COMMITTEE:

MREC approved the project.

DATE: 01 August 2013

PROF GA OGUNBANJO
CHAIRPERSON MREC

The Medunsa Research Ethics Committee (MREC) for Health Research is registered with the US Department of Health and Human Services as an International Organisation (IORG0004319), as an Institutional Review Board (IRB00005122), and functions under a Federal Wide Assurance (FWA00009419)

Expiry date: 11 October 2016

Note:

i) Should any departure be contemplated from the research procedure as approved, the researcher(s) must re-submit the protocol to the committee.

ii) The budget for the research will be considered separately from the protocol. PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES.
TSHWANE RESEARCH COMMITTEE

CLEARANCE CERTIFICATE

Meeting Date: N/A

PROJECT NUMBER: 08/2014

Title: Mental Illness and Black South African culture: exploring experiences and meanings attached to schizophrenia

Researcher: Diana Dikeledi Meduna

Supervisor: Prof W. Basset

Department: School of Medicine

DECISION OF THE COMMITTEE

Approved

NB: THIS OFFICE REQUESTS A FULL REPORT ON THE OUTCOME OF THE RESEARCH DONE

Date: 28 February 2014

Dr. K.E. Lelebele-Hartell
Chairperson Tshwane Research Committee
Tshwane District

Mrs. A. M Morewane
Director: District Health Services Support
Tshwane District

NOTE: Resubmission of the protocol by researcher(s) is required if there is departure from the protocol procedures as approved by the committee.