Hallucinations and delusions of schizophrenia among Zulu men:

An interpretive phenomenological analysis

By

Phumelele Masondo

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Supervisor: Miss C.A Prinsloo

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Abstract

The research aimed to utilise an interpretive phenomenological analysis (IPA) as method to explore themes that emerge from the hallucinations and delusions of Zulu men who had been diagnosed with schizophrenia. The theoretical framework chosen for this research was phenomenology and in particular interpretative phenomenology. A number of participants were screened for the study, however two participants were then interviewed as they were Zulu speaking and regarded themselves as being of the Zulu culture. Interviews were conducted in Zulu, transcribed in Zulu and the translated to English. Following the steps of the chosen research methodology, interpretive phenomenological analysis, themes appeared from both transcripts. Emerging themes related to how both participants see themselves as men in the Zulu culture, their relationships with their families due to their diagnosis as well as their feelings of having been diagnosed with schizophrenia. The researcher concluded that although both men have been given the same diagnosis and they both align with the Zulu culture, each participant has his own unique experiences with regards to the diagnosis they have been given. One of the possibilities for this is the context of each participant, with regards to their personal backgrounds.

Key words: Hallucinations, delusions, phenomenology, interpretive phenomenological analysis, men, Zulu culture.

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Chapter 1: Introduction

Introduction

This research dissertation aims to explore the experience of being a Zulu man diagnosed with schizophrenia. This chapter presents a brief outline of what is to the follow in the upcoming dissertation.

Background to the research will be detailed, with specific focus on the academic context of the research as well as the population and psychiatric context of the research. The justification, aim and objectives of the research will also be presented in this chapter. Interpretative phenomenological analysis will be used as methodology and method for this study. This chapter will present a rationale for this method.

As schizophrenia is a potentially debilitating disorder, the statement of the problem will be noted as well as its consideration in the South African context. This chapter will also have a brief outline of the remaining five chapters of the dissertation.

Background

For this dissertation diagnostic criteria from the DSM-IV-TR will be used. Schizophrenia refers to a cluster of disorders that are characterised by psychosis, severely impaired cognitive processes, personality disintegration, affective disturbances as well as social withdrawal (Sue, Sue, Sue & Sue, 2010). Barlow and Durand (2009) note that there are a number of disorders characterised by psychotic behaviour. These disorder include; schizophreniform disorder, delusional disorder and brief psychotic disorder. These authors state however that schizophrenia is the most prevalent of the psychotic disorders.

In the umbrella of schizophrenia there are different types of symptoms (Barlow & Durand, 2009). Positive symptoms refer to hallucinations and delusions; these are the more apparent signs of psychosis. Delusions refer to strongly held beliefs that are not held by most

members of society. Common delusions include; delusions of persecution and delusions of grandeur. Hallucinations refer to sensory events without any stimuli from surrounding environment. Examples of hallucinations include auditory and visual hallucinations (Sue et al., 2010). Between 50% and 70% of people diagnosed with schizophrenia experience hallucinations and delusions (Barlow & Durand, 2009).

Negative symptoms refer to symptoms that are associated with incapacity or decreased capacity to initiate action, speech, communicate emotion or experience pleasure (Sue et al., 2010). There are different types of negative symptoms including avolition (an inability to persist in activities), alogia (relative absence of speech) and anhedonia (lack of pleasure) (Barlow & Durand, 2009). Disorganised symptoms refer to unpredictable behaviours that affect speech, motor behaviour and emotional reactions.

The course and outcomes of schizophrenia differs from culture to culture (Barlow & Durand, 2009). According to Bentall (2004) a cross cultural manifestation of psychosis is evident amongst different cultures. It is thus important for clinicians to understand the culture in order to react suitably to the apparent distress. In this regard culture bound syndromes become integral in understanding culture and what appear to be symptoms of schizophrenia.

A number of culture bound syndromes have been well documented including *koro, latah, amok* and *dhat* (Guarnaccia & Rogler, 1999). In South Africa there are mental illnesses which are often treated by means of indigenous healing methods. These illnesses include schizophrenia, depression and anxiety (Dalasile, Paruk, Patel & Ramgoon, 2011). Culture bound syndromes documented in literature in South Africa include *ukuthwasa* and *amafufunyana.* Amongst the ethnic groups of the Xhosa and the Zulu, *ukuthwasa* refers to an ancestral calling to become a traditional healer (Zabow, 2007). *Amafufunyana* refer to being bewitched and possessed of evil spirits (Dalasile et al., 2011). Thus an overlap exists in the country between indigenous healing systems and Western treatments through psychiatric

hospitals. Sue at al. (2010) notes how culture can affect the manner in which symptoms of schizophrenia are viewed. The stigma of what is perceived to be an irreversible condition highly stigmatises those who have been diagnosed with schizophrenia.

The *Krankzinnigengesticht te Pretoria* (Pretoria Lunatic Asylum) was established in 1892 (Plug & Roos, 1992). The Asylum was the first psychiatric hospital in the *Zuid-Afrikaansche Republiek,* the then Transvaal. The Asylum was later renamed Weskoppies hospital (Plug & Roos, 1992).

Plug and Roos (1992) detail the first diagnostic classification of all 108 patients treated in 1896. Diagnoses included; stupiditas post-maniam, insania hysterica, paranoia hallucinatoria, hallucinations and idiotismus to name a few. The diagnostic classification of the 339 patients treated in 1902 included diagnoses of mania, melancholia, congenital or infantile mental deficiency and epilepsy amongst others.

Currently Weskoppies hospital has approximately 1400 beds and admits 5000 patients annually (Dlamini, 2008). The hospital caters for a range of mental illnesses. The hospital is divided into five adult firms. These adult firms cater for anxiety and mood disorders, neuropsychiatry and psycho-geriatric disorders, psychotic disorders as well as a forensic unit. The hospital also has a child unit and an adolescent unit.

Justification, aim and objectives

The research question for this dissertation is, what would an interpretive phenomenological analysis reveal about Zulu men diagnosed with schizophrenia's experiences of hallucinations and delusions?

From the literature on schizophrenia several justifications have been noted. Firstly the research is important as it will contribute to an existing body of knowledge, specifically in terms of culture and schizophrenia. This research is exploratory, thus the intent is not to evaluate therapeutic techniques or diagnostic criteria, but rather to contribute to an

understanding of this specific population. This may open up avenues for future research, which may impact the way in which therapy is conducted. An ideographic approach is taken, meaning that this research allows for an in depth investigation of one culture grouping using one methodological approach in order to inform an academic line of inquiry.

Furthermore research with Zulu men diagnosed with schizophrenia with special focus on phenomenology and the meaning of positive symptoms has not been researched before. This was verified by two independent sources, namely the researcher and the research supervisor.

The primary aim is thus to employ an interpretive phenomenological lens to investigate the themes that emerge from the hallucinations and delusions of Zulu men who have been diagnosed with schizophrenia. The following objectives serve as means of attaining the aim. Exploring the personal experience of hallucinations and delusions as meaning. Secondly to investigate the role that Zulu culture plays in the hallucinations and/or delusional belief system.

Rationale for qualitative methods

The methodology that was used for the research study is interpretative phenomenological analysis (IPA). The intent of IPA studies is the exploration of one's social and personal world (Osborn & Smith, 2008). Thus IPA is phenomenological insofar as it is concerned with the rich descriptions of an individual's life world. The subjectivity in an individual's experience and the manner in which they recount an incident is integral to an IPA study. Effort is made to explore the personal experience of these subjective experiences (Osborn & Smith, 2008). According to Larkin and Thompson (2012) the goal of an IPA study is to give voice to the experience of research participants.

IPA has an interpretive phenomenological epistemology (Larkin & Thompson, 2012). Thus interest lies in the understanding of a person's relatedness to the world through meaning

that is made. On this understanding IPA proceeds on a number of assumptions. The first assumption states that in order for one to understand the world it is required that one must understand experience; secondly in conducting research using IPA, researchers engage with the personal accounts of participants who are at all times engaged in a variety of ways notably; linguistically, relationally and culturally (Larkin & Thompson, 2012).

Statement of the problem

Irrespective of the culture, schizophrenia is a chronic and potentially debilitating disorder. Worldwide schizophrenia is the eight leading cause of disability adjusted life years in the age group of between 15 and 44 years (Calitz, Louw & Mosotho, 2011). In South Africa mental illness is pervasive, with one percent of the population having schizophrenia (Hugo & Trump, 2006). This research will be conducted on a clinical psychiatric population, thus falling under clinical mental health research.

Outline for dissertation

This dissertation will be divided into six chapters as well as an appendix section. The first chapter will give an introduction on the research to be conducted. Furthermore this chapter will introduce the research problem and research question as well as the justification of the research and qualitative method used, as well as the aims and objectives of the research.

Chapter two will provide a comprehensive literature review. This literature review will focus on a number of ideas namely gender, culture and developmental perspectives. Topics related to schizophrenia which will also be discussed, include: the definition thereof, different theoretical conceptualisations of the disorder, the phenomenology of schizophrenia as well as culture and schizophrenia.

Chapter three identifies the theoretical framework of the research. This will include a

discussion on the epistemology and ontology of the research. Furthermore there will be a discussion on phenomenology in addition to a discussion on phenomenology and schizophrenia.

The fourth chapter will discuss the research method and methodology employed for the research. Included in this are the criteria used to choose candidates for the research, the manner in which data was collected and analysed. This chapter will also take into account the role of reflexivity in the research as well as ethics in conducting research with a population of persons diagnosed with schizophrenia.

Chapter five will present the results of the case-by-case analysis. Each case will be analysed in depth, including themes and sub-themes that emerged from each case. Each of these themes will be presented accompanied with the relevant quotes. This chapter will also include a section on reflecting about the research process. This will include the researcher's thoughts of conducting the research as well as difficulties felt by the researcher in conducting the research.

The sixth chapter will present a discussion on the case-by-case analyses. Furthermore cross-analyses will be presented thus looking at differing perspective and similar instances of the participants. This chapter will be closed off with a discussion on the strengths and limitations of the research, the implications of this research and how it may impact future research. There will also be a reference list of all references across different chapters.

There will be an appendix section that includes the invitation to participate in the research, informed consent form and the interview protocol in English as well as a translated transcript of one of the participants in English.

Chapter 2: Literature Review

Introduction

Psychotic behaviour by definition has been used to characterise unusual behaviour; pertaining predominantly to delusions which are irrational beliefs and/or hallucinations which are sensory experiences that occur in the absence of external stimuli (Barlow & Durand, 2009). Schizoaffective disorder, delusional disorder and shared psychotic disorder are some of the disorders characterised by psychosis. Schizophrenia is the predominant disorder within the category of psychotic disorders.

In the literature review schizophrenia will be reviewed taking into account the definition of the psychiatric disorder, the theoretical conceptualisation of the disorder as well as the phenomenology of the disorder. The cultural aspect of the disorder will be taken into account considering culture bound syndromes along the back drop of *amafufunyana* and *ukuthwasa*. The discussion of culture will further identify research on culture and schizophrenia in the South African context.

The identifying features of the participants were taken into consideration for the literature review. The identifying features of the participants are that they are adult Zulu men who have been given a diagnosis of schizophrenia. Thus for the literature review a critical engagement was considered along the lines of gender, human development and culture.

Throughout the literature review, where applicable a critical dialogue exists between an African and a Western perspective. This critical dialogue between the two perspectives becomes essential as there exists on occasion a difference between the Western and African, in particular a South African context. This critical dialogue allows for a thorough understanding of the phenomena from both perspectives.

Gender perspective

There exist numerous debates on gender and sex. The identification of one's self as being male or female gendered constitutes a large section of these debates. In this inquiry definitions of gender and sex will be explored in addition to the examination of contemporary psychological theories on gender differences.

Sex and gender. Biologically a distinction by sex can be made between males and females. According to Rider and Sigelman (2006) chromosomal differences differentiate men and women. The chromosomal difference of XX for females and XY for males and hormonal balance pre and post birth are responsible for the differing genitalia (Rider & Sigelman, 2006).

Fausto-Sterling (1993) argues however that there are more chromosomal differences beyond the XX and XY. She is of the opinion that there exists on a spectrum of five different types of sexes. With a gradation that occurs running from male to female. The debates about biological differences appear to be a starting point in the distinction of males and females.

Different authors have considered ideas around gender differences between men and women. According to Rider and Sigelman (2006) there appears to be a societal expectation for males and females to adopt different gender roles. Well known authors in the field of gender and gender stereotypes Crowley and Eagly (1986) consider in detail the effect of gender roles.

According to them gender roles take into account ones socially identifiable gender and the norms applicable to the gender. These gender role stereotypes tend to emerge from the norms governed by society's expectations and standards on the roles of males and females (Crowley & Eagly, 1986). In addition they are of the opinion that gender role stereotypes tend to be largely inaccurate with overgeneralisations on ways that males and females should be like.

These stereotypes are seen in Crowley and Eagly's (1986) article on gender and helping behaviour. The female gender role in this instance is seen as being oriented towards being caring and nurturing. Furthermore females are seen as being more empathetic and sympathetic than their male counterparts (Crowley & Eagly, 1986). Alternatively males are placed in the gender role of being heroic, chivalrous, and adventurous in addition to taking the lead and staying calm under pressure (Crowley & Eagly, 1986).

Psychological theories on gender. As discussed previously the differentiation between males and females appears to be first and foremost at a biological level. This chromosomal difference of XX for female and XY for males starts the differentiation between both sexes. Gender norms and gender stereotypes appear to complicate matters as they pertain to society's ideas on how men and women should behave. Psychological theories on gender are thus considered as a means to further explain sex differences.

Psychology has also contributed to the debate on the differences between men and women. Shefer (2004) is of the opinion that psychology has played a large role in perpetuating the difference between men and women. In this regard psychology's role has contributed to the production of the dominant construction of gender in addition to subsequent power inequalities. This would appear to further add to debates on the construction of gender and the distinction between men and women.

Psychological theories on sex and gender thus allow for diverse perspectives on gender and sex differences. In producing adequate explanations of these differences Eagly and Wood (2004) are of the opinion that psychological theories need to take into account factors that have, and have not been explored before. Thus in taking into account those causes which have not been explored before furthers an understanding of those causes which have been explored. Eagly and Wood (2004) further argue that distal causes such as biological processes, genetic factors and features of social structures have often been sidelined in the

formation of psychological theories. Psychological theories have thus focused on more proximal causes for sex differentiated behaviour including gender roles and socialisation (Eagly & Wood, 2004).

A number of theories have been identified in the field of psychology to better explain sex differences of which two will be briefly overviewed. From an evolutionary psychology perspective the works of Buss (1995) and Luxen (2007) give clear commentary on sex difference. Evolutionary psychology states that men and women will be similar in domains in which both sexes have had to have the same adaptive problems. Conversely in other domains males and females have experienced adaptive problems unique to their sex, for instance childbirth in females (Buss, 1995).

The different roles occupied by males and females in reproduction has for evolutionary psychologists been an explanation for human sex differences (Luxen, 2007). Furthermore it is supposed from this stance that the different roles have led to different selection pressures on men and women resulting in different cognitive mechanisms. Key aspects for evolutionary psychology then are not whether men and women differ psychologically.

According to Buss (1995) the question becomes threefold; looking at the domains in which men and women have experienced different adaptive problems, an identification of the sex- differentiated psychological mechanisms which have evolved in reaction to aforementioned sex- differentiated adaptive problems. The last of the key questions involves the identification of cultural, social and contextual inputs which sets the parameter for the expression of sex differences.

The biosocial theory has differing views on gender and sex differences. This theory focuses on the reciprocal interaction between the physical characteristics of men and women as well as the society's in which they live (Eagly & Wood, 2002). Biosocial theory argues

that as a result of biological developments in infancy people react to children differently in accordance with their sex. The manner in which children are thus reacted to suggests that these social interactions play an integral role in the assumption of a gender role (Rider & Sigelman, 2006).

Thus according to biosocial theory it is important to take into account both biological and social aspects. In taking the biological component into account, chromosomal differences and hormone balances between males and females explains sex difference. This theory further expands itself in taking into account gender norms and stereotyping, which appear to come from the aforementioned biological aspect of the theory.

Rider and Sigelman (2006) note the influence of social labelling in the biosocial theory. In this regard the labelling of children and the manner in which they are treated correlates highly with gender development. Thus in keeping to gender norms and stereotypes the different ways in which children are treated in accordance to their sex plays into creation of gender norms and stereotypes.

Developmental perspective

The life cycle of human development has been posited through a number of theorists. Theories range from the psychoanalytic theory of Freud, learning theories, cognitive developmental theory as well as contextual- systems theories (Rider & Sigelman, 2006).

The ideas of Erikson are well known in his conceptualisation of the stages of human development. The coming of age and becoming an adult in certain cultures of South Africa takes place in a manner quite distinct from Erikson and other theorists. Thus a detailed description of these cultures will be made along with their manner of coming of age.

Erikson described an eight stage theory of life cycle development, from infancy to old age (Slater, 2003). Although Erikson was grounded in psychoanalytic theory he rejected the Freudian notion of a fixed personality, shaped by early childhood experiences (Slater, 2003).

In this manner Erikson extended his stages of human development to adolescence, adulthood and old age. Erikson lends from Freud's theory on psychosexual development as the ages in which people go through each stage are based on Freud's description of psychosexual stages of development. Erikson however extends on them, giving credence to the adolescent task of identity development as well as the conflicts of adult development (Slater, 2003).

Rider and Sigelman (2006) note how maturational forces and social demands push individuals all through the eight stages. Furthermore for there to be development that progress optimally a healthy balance needs to exist between the terms of conflict at each stage (Rider & Sigelman, 2006).

Arnett (2000) considers the idea of an emerging adulthood. The focus becomes on the identity period where one is no longer an adolescent but can neither be considered a young adult. Emerging adulthood according is characterised by an independence from childhood and adolescence without the full responsibility of adulthood (Arnett, 2000).

Arnett's (2000) ideas on emerging adulthood are influenced by the works of Erikson. Erikson does not speak of an emerging adulthood but rather a prolonged adolescence in which individuals find their niche in society Erikson. Emerging adulthood however is not a universal period. This will only occur in cultures where there is a postponement of entry into adult roles and responsibilities (Arnett, 2000). Thus similar to the ideas of Erikson and prolonged adolescence, emerging adulthood can only take place in highly industrialised or post-industrial countries.

Countries like these require high levels of education to gain entry into specific occupations. Therefore many individuals remain in schooling for longer periods of time, well into their mid twenties to gain prestigious and lucrative occupational positions (Arnett, 2000). As a result of this marriage and parenthood is postponed in order to finish schooling. This allows for a period of self exploration of various relationships in addition to an exploration of

different job opportunities before having to be financially supportive of a family (Arnett, 2000).

Adulthood in some South African indigenous cultural groups is obtained in a manner different to the aforementioned theories of adulthood. Adulthood is obtained through customary practices. It is only after young men and women have been through certain rituals that they then have made the transition from young boys to men and from young girls to women.

Culture and adulthood. In some ethnic populations there comes a link between culture and adulthood. Rituals and customary practices for both men and women take place in the coming of age. These customary practices symbolising the rite of the passage into adulthood are practices among the diverse ethnic populations of South Africa. In this section these rites of passage of South African ethnic populations will be detailed, including the population that will be used for the research.

Traditional rituals signify a rite of passage into adulthood in certain South African cultural groups. According to Bottoman, Mavundla, Netswera and Toth (2009) cultural groups in South Africa that practice such customs include the Xhosa, Sotho, Pedi, Venda and the Tsonga.

Customary practices for men and women in their rite of passage to adulthood differ. The divide in practice between men and women is noted by Maharaj, Malisha and Rogan (2008) in that the women are prepared for roles as mothers and caregivers whereas male practices centre on ideas of being brave and dominant. This difference according to Maharaj et al. (2008) is an important cultural component of their social lives.

For women the rite of passage into adulthood begins with an onset of physical maturity. Maharaj et al. (2008) notes how a young girl's first menstrual cycle denotes the onset of maturity, which begins her rite of passage into adulthood. Similarly Jeannerat (1997)

in her fieldwork on Venda women and the Vhusha ceremony, an initiation ceremony for girls, noted how young girls are only eligible to become a part of the ceremony after their first menstrual cycle.

The rite of passage and traditional ceremonies for women centre on being prepared for being wives and caregivers. Knowledge is imparted on young girls during ceremonies on marriage customs and the traditional household gender roles (Maharaj et al., 2008). In addition to knowledge conveyed on marriage customs and traditional gender roles young girls are also taught about sex and sexuality (Jeannerat, 1997). The knowledge acquired during these ceremonies is bestowed on them by the elder women in their communities.

Women who do not take part in the ceremonies are looked down on in their communities. In Jeannerat's (1997) fieldwork she notes how uninitiated women are ridiculed by other women. She further notes how these uninitiated women are despised to such a degree that they are not allowed to be friends with initiated women. Similar types of ridicule are experienced by men from cultural groups where there is a rite of passage into adulthood and, who have not currently done so.

Young boys who have not taken the rite of passage into adulthood and haven't been initiated are teased and ridiculed (Oomen, 2002). Furthermore Vincent (2008) also noted a discrimination against uninitiated men by men who have been initiated. This discrimination along with ridicule and teasing includes treating uninitiated men as if they were young boys (Vincent, 2008). In the identification of Venda males in Limpopo, Maharaj et al. (2008) noted a stigma that had been placed on males who had not been initiated. Stigma centred on not being considered a real man because one had not been initiated yet (Maharaj et al., 2008).

The rite of passage into adulthood for Xhosa males is seen as having elements of symbolism (Vincent, 2008). The prevailing symbolism identified by Vincent (2008) is that of heterosexual manhood. Bottoman et al. (2009) note how initiation practices symbolise a

rebirth of the initiates wherein they become men. Once a male has been through the initiation practices, which includes being circumcised, a transition takes place, from childhood to manhood (Maharaj et al., 2008). It is only after they have been through initiation practices that males are considered ready to marry and start their own families (Maharaj et al., 2008).

Men who have been circumcised play a greater role in their communities (Vincent, 2008). This responsibility is given to them as they are now considered adults in their communities. To be able to take up the responsibility in their communities, start a family and become a husband are all taught to them while going through initiation practices. Similar to female initiates it is here where they learn about sex and sexuality in addition to bravery and dominance (Jeannerat, 1997; Maharaj et al., 2008; Vincent, 2008). In transitioning into manhood Bottoman et al. (2009) further note that learning for these men includes learning about dating, marriage as well as employment.

Thus the process of initiation practices for men is one where they are prepared for their roles as men in their communities and in their families. In this regard learning which takes place centres on aspects which would be considered as important for them in their new roles as men.

There is a clear distinction on how adulthood is achieved when contrasting more Western ideas of adulthood to that of an African perspective. Western ideas of adulthood include individual aspects that then lead to one being considered an adult. An example of this can be seen in one's age. According to the Children's Act, Act 38 of 2005 a minor reaches majority when they are 18 years old.

An African perspective differs from this Western idea, in that it looks at more than a single marker to attribute reaching adulthood. This point is stated by Jeannerat (1997) in the fieldwork done in Venda, South Africa.

Jeannerat (1997) is of the opinion that adulthood; specifically in Tshiendeulu Venda, is not attributed by age or any one single marker in that:

> It was rather connected to the experience of several events: the initiation ceremonies (for a woman, *musevhetho, whusha* and *domba,* and, for a man, *mula/murundu, tshitambo* and *domba),* marriage, and parenthood. When a person has achieved all these things, it was suggested, he/she may rightfully attend the *khoro* meetings, a symbol of adulthood (p. 96).

Within the life cycle, adulthood plays a significant part in one's development. From both Western and African perspectives adulthood is a period marked with transition. Transitions are such that the role of individuals with greater responsibility placed on them from a number of different domains in their lives.

Cultural perspective

Culture, ethnicity and race have long been debated and defined in a variety of fields including anthropology and psychology. In the South African context, a context rich in diversity, different ethnic and cultural variances exist. The diverse ethnic and cultural elements of the country allows for a varied understanding of the people of the country.

In this section culture and ethnicity will be identified, along with brief contextual descriptors of the country. As the population for the study focuses on the ethnic grouping of the Zulu a brief inquiry into the Zulu will be made.

According to Hwang and Matsumoto (2012) there appears to be no consensus in defining culture as it is defined differently by different authors. For them culture, meaning and information enhances social coordination. In enhancing social coordination they are of the opinion that culture becomes twofold in that; a greater differentiation among social groups can be identified and cultural practices and customs become institutionalised. In the

institutionalisation of cultural practices and customs the adherence to norms becomes encouraged (Hwang & Matsumoto, 2012).

According to Sadock and Sadock (2007) cultural identity denotes "the internalised self-definition resulting from the persons selective, developmentally mediated incorporation of values, beliefs, history and customs from those available in that persons native environment" (p. 169). Thus culture and cultural identity becomes multi-faceted. It contains many dimensions of self experience which can include amongst others age, gender, race, sexual orientation ethnicity and spiritual beliefs (Sadock and Sadock, 2007).

Culture appears to define a social grouping which within itself has its own norms and customs which become specific to the group. Cultural identity which arises from the available environment of people comes with internalised values, beliefs and customs (Sadock and Sadock, 2007).

One of the many dimensions of a cultural identity according to Sadock and Sadock (2007) is ethnicity. Different definitions of ethnicity overlap in their identification of a common identity. For them ethnicity signifies the sharing of a common identity, encapsulated shared ancestry and beliefs. Developmental experiences exist that are therefore shaped by one's ethnicity, including special rituals and the rites of passage and adherence to these practices (Sadock & Sadock, 2007).

For Campbell and Maré (1995) ethnicity is seen as characterised as a form of social identity. Ethnicity is then seen by them as a combination of three elements which overlap each other. The first of these elements speaks to the commitment to culturally distinct norms including practices and symbols. In the second element they are of the opinion that this commitment to culturally distinct norms links individuals to a common identity, such that there is a sense of a common historical origin. Lastly this sense of belonging to a group becomes experienced as different from other groups (Campbell and Maré, 1995). In

conceptualising ethnicity in this manner they are of the opinion that ethnicity is therefore not a fixed construct but it rather though historical constructions that they come to be.

Similar to Campbell and Maré (1995), De Haas and Zulu (1994) note the sense of a common belonging in ethnic awareness. Ethnic awareness thus appears to be promoted by feelings of being different from others. Ethnicity and ethnic identity can thus be seen as a sense of belonging to a specific grouping of individuals. In one's ethnic identity cultural, distinctive practices are present only specific to that grouping of individuals (De Haas & Zulu, 1994).

South Africa in its diversity has different ethnic groupings for which customs and practices are kept. The heterogeneous nature of South African society is such that many different communities exist each keeping with their own culture and variety of language (Meiring, 2008). A unique South African identity exists, however according to Meiring (2008) it becomes difficult to consider due to the great deal of diversity that exists.

South Africa has a rich history, from human ancestry and the colonisation of settler's, war and apartheid to the modern day South Africa. Human ancestry of the country dates back to what appeared to be three million years ago (Aliprandini, 2011).

The San, hunter gatherers and the Khoikhoi nomadic herders' origins date back thousands of years ago. The Bantu- speaking people later migrated from the northwest of Africa (Aliprandini, 2011). After this period Dutch colonialist arrived in the region in 1652, which was followed by the British a century and a half later (Aliprandini, 2011). Many countries have left their mark on the country including Portugal, Netherlands, Germany, France and Britain (Meiring, 2011).

An estimate of the total population in 2011 by Statistics South Africa (Stats SA, 2011) was 50, 586, 757 people. This is further comprised of a white population mainly of Dutch and English descent, an Asian population which includes a Malaysian and Indian population,

individuals of mixed ancestry and the black population which is also divided into several groups and of which the Zulu and the Xhosa are in the majority (Aliprandini, 2011).

The country has eleven official languages (Aliprandini, 2011; Joyce, 2009) namely English, Ndebele, Afrikaans, Pedi, Sotho, Swazi, Tswana, Tsonga, Xhosa, Venda and Zulu. Of the ethnic black languages they can be categorised into two systems the Sotho and the Nguni languages respectively (Joyce, 2009). The other ethnic black languages that exist are dialects of these two systems (Joyce, 2009).

Other languages exist in the country, including several Indian languages (Aliprandini, 2011) plus the language of the San and Khoikhoi, including their dialects Koranna, Griqua and Nama (Meiring, 2008). Presently there is a high rate of multilingualism with English being used as a second language for a number of South Africans (Aliprandini, 2011).

De Hass and Zulu (1994) identified elements of ethnic awareness among Zulu people. They noted a number of characteristics in the manner in which individuals identify themselves as belonging to this particular ethnic grouping. Although they had as their focus an inquiry into ethnic awareness, individuals foremost identified themselves primarily as being black or African.

According to De Haas and Zulu (1994) there appears to be a variation in the manner in which individuals identify themselves as belonging to this ethnic population. The formation of a Zulu ethnic identity in their study appears to vary from spoken language as well as individuals' relation to other ethnic populations.

Ethnic identity according to geography for De Haas and Zulu (1994) is rare but noted. In this manner individuals see themselves as being Zulu by living in KwaZulu Natal, or by being in proximity to a number of other Zulu people. Furthermore individuals ethnically identified with being Zulu through language. In their study De Haas and Zulu (1994) note that many individuals identify as being Zulu primarily because they speak the Zulu language.

Ceremonial activities engaged in play a large part in ethnic awareness. In their study participation in ceremonies promotes personal identity to being Zulu. In turn there are feelings of ethnic solidarity and of standing out as different to other ethnic groupings. The "Zulu dance" is an example of a custom unique to being Zulu (Campbell & Maré, 1995; De Haas & Zulu, 1994). When this dance or any other ritual activity unique to the Zulu culture is performed there appears to be a heightened ethnic awareness (De Haas & Zulu, 1994).

Similar to a heightened ethnic awareness when performing rituals and customs unique to being Zulu, participants in De Haas and Zulu's (1994) study also felt a heightened sense of belonging in company of individuals not of their ethnic grouping. Thus in company of individuals whose language, ritual and customs differed from theirs, there came through a stronger sense of being Zulu. In this regard they are of the opinion that difference amongst ethnic groupings promotes ethnic awareness.

Amasiko or customs in Zulu which surround significant events such as birth, marriage and death are integral and centrally important for the majority of the participants in De Haas and Zulu's study (1994). As important as these customs are they are afforded importance along the influence of age, class and religious affiliation (Campbell & Maré, 1995; De Haas and Zulu, 1994).

When a Zulu child is born this child is introduced to the ancestors as according to Ntsimane (2007) they partook in the child's procreation. The child is then integrated into the family and various rites of passage take place such as *ukubikwa* and *imbeleko* and for post adolescent girls, *umemulo.* These rituals are meant to call up on and uphold the presence and protection of the child from their birth, to their death (Ntsiman, 2007).

Mchunu (2005) is of the opinion that the language of respect is prominent among Southern Africa's indigenous cultures. According to Ntsimane (2007) *ukuhlonipha*, to show respect, has been espoused by Zulus and other ethnicities from time immemorial as a means

to regulate relationships amongst family and other clans. Furthermore to show respect helped in creating a pleasant existence among all. In its broadest sense *ukuhlonipha* is when younger people show respect to older people. *Ukuhlonipha* according to Mchunu (2005) and Ntsimane (2007) relates in particular to women and children. In that they are to be respectful of the men, whom are the heads of the household.

To respect is indicative of masculinity, where women and young children are expected to, along with the head of the household, maintain the dignity of the home (Mchunu, 2005). For the head of the household to be disrespected by wife and children would then lead to him being disrespected by the community. In this regard young sons learn respect from their fathers by observing their behaviours which they will carry through when they become fathers (Mchunu, 2005).

Mzulwini (1996) discusses the patriarchal family as being the norm in the Zulu family. In this regard the head of the household, the husband has authority over his wife and children. The manifestation of this according to Mzulwini (1996) is "a dominant relationship of love, authority and understanding in the family" (p.14). A child who is thus brought up in a family of this manner is accepting of the authority that elder family members have over them.

Uchendu (2008) describes the disciplined nature of the Zulu culture. He is of the opinion that Zulu people were subject to relentless discipline. However it was this discipline that would make them respectful, brave and honest. He further states that these virtues are learned through the family. Historically the Zulu boy of the nineteenth and twentieth century according to Uchendu (2008) was not inactive or lazy. Both parents played an active role in the young Zulu boy's life in grooming him for manhood.

Historically, living up to Zulu masculinity was a combination of "martial prowess with honesty; high morality, as shown in the absence of premarital penetrative sexual

interaction with female subject even though intimate encounters were allowed; loyalty; aggression; a sense of responsibility; courage; self-reliance; athleticism; alertness; endurance; and absence of emotions" (Uchendu, 2008, p. 8). To not live up to these standards could bring public shame and consequences to him and his family. Severe forms of repercussions could include; his father's cattle being confiscated, his disinheritance, banishment or even death (Uchendu, 2008).

Culture and ethnicity becomes crucial in the South African context as it is a country rich in diversity. Definitions of culture focus on societal groupings whereas an ethnic identity refers to the sharing of common identity, common ancestry and shared beliefs and history (Sadock & Sadock, 2007).

In South Africa there exist a number of different ethnicities of which the Zulu and the Xhosa make up the largest populations among the black ethnic groups. Different contextual descriptors have been identified in indentifying oneself as a part of the Zulu's. Of those that have been noted this includes language, location, and difference in relation to other ethnic groups and customary practices unique to being Zulu.

Different cultures and ethnic groups have their own contextual descriptors unique to their culture. In this instance a detailed description of that of the Zulu was noted as research participants ethnically identified as being Zulu.

Schizophrenia

A number of disorders exist that are characterised by psychotic behaviour. Disorders including; schizoaffective disorder, delusional disorder and shared psychotic disorder are such disorders characterised by psychosis.

Psychosis is characterised by unusual behaviour, including hallucinations and delusions. Of the disorders characterised by psychotic behaviour schizophrenia is the most primary disorder.

Literature included for the review of schizophrenia focuses on distinct elements, more specifically taking the research project into account. The review firstly focuses on schizophrenia as definition. Subtypes of schizophrenia are defined, in addition to an explanation of the positive, negative, and disorganised symptoms of schizophrenia.

The second part of the review will focus on a theoretical conceptualisation of schizophrenia. A theoretical conceptualisation allows for a better understanding of schizophrenia in addition to the historical findings of this psychiatric disorder.

Additionally the phenomenology of schizophrenia will be taken into account. This entails a review of schizophrenia from a phenomenological standpoint, an overview of the accounts of individuals who had been diagnosed with schizophrenia or other psychotic disorders and lastly, past research identifying the phenomenology of schizophrenia.

Furthermore the experiences of individuals who have experienced a psychotic episode or have been given a diagnosis of schizophrenia have been included. Culture will also be considered and will focus on schizophrenia within some South African cultures.

Schizophrenia defined. The fourth edition, text revision of the *Diagnostic and Statistical Manual* (DSM-IV-TR, 2000, p. 273) identifies the essential features of schizophrenia as being: A disturbance that lasts at least six months and includes at least one month of active phase symptoms (i.e two [or more] of the following: delusions, hallucinations, disorganised speech, grossly disorganised or catatonic behaviour, negative symptoms).

The tenth revision of the *International Classification of Mental and Behavioural Disorders* (ICD-10, 1992) characterises schizophrenic disorders as having “fundamental and characteristic distortions of thinking and perception, and by inappropriate or blunted affect” (p.78).

There are five main subtypes of schizophrenia; namely Paranoid, Disorganised,

Catatonic, Undifferentiated and Residual Type (DSM-IV-TR, 2000). The ICD- 10(1992) includes three other subtypes, namely Hebephrenic and Simple schizophrenia plus Post-schizophrenic depression.

Each of the various subtypes has characteristic symptoms engrossing a range of emotional and cognitive functions including "perception, inferential thinking, language and communication, behavioural monitoring, drive and attention" (DSM-IV-TR, 2000 p. 274).

The manner in which the disorder develops and progresses throughout its course is dependent on the different subtype it falls under (ICD-10, 1992).

Symptoms of schizophrenia have been noted across a variety of cultures (Barlow & Durand, 2009). Thus according to Barlow and Durand (2009) there is universality to the disorder, wherein all racial and cultural groups are affected.

The onset of schizophrenia may occur in one of two ways. It may be acute with behaviour that is seriously disturbed. On the other hand it may be occurring in an insidious manner, gradually developing characterised by odd and peculiar conduct.

Characteristic symptoms fall into two broad categories of positive and negative symptoms. Barlow and Durand (2009) identify a third category, disorganised symptoms. Whereas Sue et al. (2010) identify a further two symptoms apart from the positive and negative; including cognitive symptoms and psychomotor abnormalities.

Disorganised symptoms according to Barlow and Durand (2009) are the least studied and thus are the least understood of the symptoms. Disorganised speech as well as inappropriate affect and disorganised behaviour make up these symptoms.

Cognitive symptoms pertain to difficulties in attention and memory. This is noted by difficulties in executive functioning in that there are deficits "in the ability to absorb and interpret information and make decisions based on that information, to sustain attention, and to retain and use recently learned information" (Sue et al., 2010, p. 381).

Psychomotor abnormalities include motor functions that may be deemed peculiar or bizarre (Sue et al., 2010). Catatonia is one such condition which is noted by extremes in activity level, bizarre body movement and postures, peculiar grimaces and gestures or they may be a combination of all these (Sue et al., 2010).

Negative symptoms appear to reflect a loss of normal functions (DSM- IV- TR, 2000). Symptoms include "marked apathy, paucity of speech, and blunting or incongruity of emotional responses, usually resulting in social withdrawal and lowering of social performance" (ICD-10, 1992, p. 79).

Four categories of negative symptoms are identified. This includes avolition (an inability to initiate and persist in activities); alogia (deficits in speech marked with relative absence of speech), anhedonia (presumed lack of pleasure experience) and affective flattening (the lack of affective expression) (Barlow & Durand, 2009; Sue et al., 2010).

Positive symptoms reflect an excess or distortion of normal functions (DSM-IV-TR, 2000). Barlow and Durand (2009) note that positive symptoms are the more apparent signs of psychosis which include hallucinations and delusions. As the focus of the research is on these positive symptoms of schizophrenia, hallucinations and delusions will be further explored.

Delusions or disorders of thought content are beliefs seen by most members of society as detached from reality, and common components in psychotic disorders (Arieti, 1974; Barlow & Durand, 2009; Cannon & Kramer, 2011).

Coltheart, Langdon and McKay (2007) are of the opinion that a distinction needs to be made between an illusion and a delusion. Although they both deal with a misperception of reality, they differ in their manner in that:

> If illusions involve low-level misperceptions of reality, then delusions involve cases of high-level misbelieve instances where the avowed contents of an individual's beliefs run counter to a generally accepted reality. The prevailing diagnostic view of

> delusions is that they are rationally untenable beliefs that are clung to regardless of counter-evidence and despite the efforts of family, friends and clinicians to dissuade the deluded individual (p.932).

Similar to the aforesaid difficulty between an illusion and a delusion a distinction also needs to be made between a delusion and a strongly held belief. This distinction is usually dependent on the degree of conviction in the face of clearly contradicting information (DSM-IV- TR, 2000). Thus the stronger the conviction the more likely the individual is experiencing a delusion.

Another point of consideration involves the aforesaid bizarre quality of delusions. The bizarre quality of delusions may be difficult to judge, especially if one considers delusions along the background of different cultures. What one culture may perceive as bizarre may not be judged as such by another culture. Delusions have thus been deemed bizarre when "they are clearly implausible and not understandable and do not derive from ordinary life experiences" (DSM-IV- TR, 2000, p. 275).

Content of delusions include a variety of themes; ranging from persecution and religion to grandiose, referential and somatic themes (DSM-IV-TR, 2000; Sadock & Sadock, 2007). Persecutory and referential delusions appear to be the most common (Barlow & Durand, 2009; DSM-IV-TR, 2000); such that individuals are suspicious of others and their intentions towards them. Individuals experiencing referential delusions are of the belief that environmental cues such as people's gestures or comments, newspapers, books et cetera are directed towards their behaviour (DSM-IV-TR, 2000).

The *loss of ego boundaries* is important to consider in the discussion of schizophrenia and specifically delusions. Sadock and Sadock (2007) describe this as pertaining to the "lack of a clear sense of where the patient's own body, mind, and influences end and where those of other animate and inanimate objects begin" (p. 492). The *loss of ego boundaries* is thus

evident in the content of certain types of delusions, namely referential delusions as well as somatic delusions.

Coltheart et al. (2007) note how delusions can vary from the "circumscribed and nomothetic to the widespread and polythematic" (p. 933). In this regard an individual can be articulate and grounded on topics removed from delusional content, whereas other individuals demonstrate a more extensive loss of contact with reality.

Diagnostically the range in which delusions can fall under is quite significant, influencing the possibility of differential diagnosis. Individuals who exhibit more bizarre delusions are more likely to be given a diagnosis of schizophrenia whereas individuals with relatively monotonous delusions are more likely to be given a diagnosis of delusional disorder (Coltheart et al., 2007; DSM-IV- TR, 2000).

Hallucinations make up the second category of positive symptoms for this study. Hallucinations are identified in individuals who "undergo percept like experiences in the absence of external stimuli" (Jones, 2010 p. 187). Perceptual disturbances may affect any of the senses, such as auditory, visual, olfactory, gustatory and tactile senses (DSM-IV-TR, 2000).

Auditory hallucinations are considered the most common type of hallucination (Barlow & Durand, 2009; Jaspers, 1963; Sadock & Sadock, 2007; Suri, 2011). Individuals with the paranoid type of schizophrenia are seen as most susceptible to preoccupations of delusions and/or frequent auditory hallucinations (Sadock & Sadock, 2007). An individual's current behaviour and thoughts may be commented on through the auditory nature of their hallucinations (ICD-10, 1992). Visual hallucinations are also quite common; with tactile, olfactory and gustatory hallucinations being uncommon types of hallucinations (Sadock & Sadock, 2007; Sue et al., 2010).

The DSM-IV-TR (2000) states that auditory hallucinations are experienced as voices,

viewed as either familiar or unfamiliar to the individual and experienced as distinct from the individuals own thoughts. The content of hallucinations, similar to delusions has a broad range, with negative or threatening voice appearing to be the most common (DSM-IV-TR, 2000). Auditory hallucinations without verbal form can be experienced which can include laughing, humming or whistling (ICD-10, 1992).

Hallucinations according to the DSM-IV-TR (2000) must occur in a clear sensorium. Thus if an individual experiences a hypnagogic hallucination, that occurs while falling asleep or a hypnopompic hallucination whilst waking up this does not mean that the person suffers from schizophrenia (DSM-IV-TR, 2000).

Theoretical conceptualisation of schizophrenia. Significant alterations have been made to the understanding of schizophrenia since the early 20th century (Wood, 2010). Theorists of the early 20th century were of the opinion that schizophrenia and its subtypes were similar to neurological disease (Sampson, 2009; Wood, 2010).

In understanding the aetiology of the condition psychological and social formulations arose (Wood, 2010). The absence of brain abnormality propelled the shift in the conceptualisation of schizophrenia. Therefore the shift came in conceptualising schizophrenia from a neurological disease to more psychological formulations (Wood, 2010).

Barlow and Durand (2009) note the historical evolution of schizophrenia over time. In considering the history it allows for a greater understanding of the nature of the disorder and an appreciation for the multifaceted aspects of it (Barlow & Durand, 2009).

A number of physicians over the past several centuries have been credited in their identification of symptoms of schizophrenia. John Haslam in 1809 outlined a description of the symptoms of schizophrenia. Additionally the Philippe Pinel started writing up cases of people who would had been diagnosed with schizophrenia (Barlow & Durand, 2009).

The first person to label the clinical picture of schizophrenia as a syndrome was

Belgian psychiatrist Morel (Barlow & Durand, 2009; Sadock & Sadock, 2007; Weiner, 1966). The term used by Morel was *démence précoce* in describing an early manifestation of dementia (Barlow & Durand, 2009; Bentall, 2004; Sadock & Sadock, 2007). From Morel onwards more theorists began to write about schizophrenia and thus enable a greater clinical picture of the disorder.

Emil Kraeplin. One of the central figures in the history of psychiatry is Emil Kraeplin (1856- 1926). He is credited for diagnostic concepts ranging a broad variety of psychiatric disorders, ranging from psychosis to depression (Bentall, 2004; Gaebel & Zielasek, 2009; Pao, 1979). Kraeplin interests fell into the category of more severe forms of madness wherein the individual had appeared to lose touch with reality (Bentall, 2004).

According to Kraeplin mental illness fell into smaller categories which can be identified in three ways by "studying symptoms, by direct observations of brain diseases, or by discovering the aetiologies of the illnesses" (Bentall, 2004, p. 13). In his identification of psychoses Kraeplin attempted to establish how many different types of psychoses are present (Bentall, 2004).

Kraeplin grouped together illnesses within the psychoses which included *catatonia*, characterised by stupor an abnormal posture, *hebephrenia* a disease found in adolescence leading to a deterioration of mental functions and lastly *dementia paranoides* which leads to rapid deterioration characterised by bizarre fears of persecution (Barlow & Durand, 2009; Bentall, 2004). Kraeplin translated Morel's *démence précoce* to *dementia praecox* a term emphasising the distinct cognitive and early onset of the disorder (Barlow & Durand, 2009; Bentall, 2004; Sadock & Sadock, 2007)

The Latin term *dementia praecox* means the "senility of the young" (Bentall, 2004, p. 15) which demonstrates what Kraeplin had noted about the numerous subtypes, in that various symptoms showed their first appearance either in adolescence or early adulthood

(Bentall, 2004). Characteristic symptoms of *dementia praecox* included an absence or highly inappropriate emotions, stereotypic behaviour or the adopting of catatonic postures (Bentall, 2004; Weiner, 1966).

Furthermore patients may exhibit problems of attention, auditory and tactile hallucinations as well as irrational beliefs of either grandiosity or delusions of persecution (Bentall, 2004; Weiner, 1966). What appears to be the common feature for Kraeplin is the irreversible deterioration of mental functions, such that they are unable to continue with productive lives. Kraeplin (1896) further details the inability to live productively by stating:

> His intellectual horizon narrows; easy relationships with the outside world shrivel away. As a rule he gradually loses all interest in mental activities or mental stimulation, his thoughts move only in well- worn stereotyped grooves and in the end he may be limited to mechanical activity- sawing wood, copying, gardening- often in sharp contrast to earlier ambitions, plans and hopes (p. 428).

Wood (2010) notes how though Kraeplin had a tremendous influence in the field of schizophrenia he rejected the psychological contributions to the aetiology of the disorder. Kraeplins' focus was thus focused on the neurology of the disorder stating that *dementia praecox* had been caused by degenerative disease of the brain or metabolic disturbance of the morbid processes in the brain (Kraeplin, 1896).

Eugen Bleuler. In his classic work *Dementia Praecox or Group of Schizophrenias* Eugen Bleuler (1857- 1939) produced text that remains current in the understanding of schizophrenia disorders (Weiner, 1966).

A significant difference exists between Kraeplins *dementia praecox* and Bleulers' schizophrenia (Sullivan, 1974). Bleuler (1911/1950) was of the opinion that *dementia praecox* as defined by Kraeplin was misleading in two respects. The first point that Bleuler finds misleading refers to Kraeplins idea of mental deterioration; according to Bleuler not all

individuals with the illness experience an extreme form of complete deterioration (Bleuler, 1911/1950). The second misleading point refers to the age of onset of the illness; Bleuler (1911/1950) argues that though the illness had been identified in late adolescence and early adulthood the illness sometimes first appeared in later life.

Bleuler thus conceived the term schizophrenia which replaced Kraeplins *dementia praecox* (Barlow & Durand, 2009; Sadock & Sadock, 2007). Schizophrenia is the combination of the Greek words *schizin* (to split) and *phren* (mind) which reflected Bleuler's belief that underlying all the behaviour exhibited by individuals with this disorder is an associative splitting of the personality (Barlow & Durand, 2009; Sadock & Sadock, 2007; Weiner, 1966). According to Bleuler (1911/1950) the integration of psychic complexes becomes lacking to the point that "one set of complexes dominates the personality for a time, while other groups of ideas or drives are 'split off' and seem either partly or completely impotent" (p. 9).

Kraeplin and Bleuler shared similar thoughts on the biological component of the disorder (Bentall, 2004). Where Kraeplin only focused on the biological component through the disease process in the brain, Bleuler was also interested in the psychology behind the illness (Bentall, 2004). In identifying the psychology of his patients' symptoms Bleuler noted how symptoms can vary from one individual to another (Bentall, 2004).

In an attempt to make sense of these variations among patients Bleuler made use of ideas from Freud and psychoanalysis (Bleuler, 1911/1950). In making use of Freud's ideas he combined them with his own ideas about mental mechanisms which he saw as responsible for adequate thinking and reasoning (Bentall, 2004). The psychopathology of schizophrenia becomes an interesting aspect of the disorder as it allows for a multi- faceted understanding of the patients who have the disorder in addition to the healthy psyche (Bleuler, 1911/1950).

The distinction between primary and secondary symptoms becomes important for

Bleuler (1911/1950) as one can "only understand a psychically determined psychosis if we distinguish the symptoms stemming directly from the disease process itself from those secondary symptoms which only begin to operate when the sick psyche reacts to some internal or external processes" (p. 348). For Bleuler this approach led him to believe that beneath the most varied symptoms of the disorder there lay an inner unity, identified by four subtle symptoms he believed to be integral to the illness, known contemporarily as Bleulers A's (Bentall, 2004; Sadock & Sadock, 2007).

The first of these symptoms that Bleuler (1911/1950) referred to were the disturbances of *association*. These difficulties in *association* refer to the inability to link together ideas or a stream of thought rendering the individual incapable of reasoning coherently (Bentall, 2004). During these clouded states (*Benommenheitszustände)* a variety of symptoms become present which include tremors, weakness as well as catatonic stupors (Bleuler, 1911/1950).

The following symptom Bleuler (1911/1950) expands on is *affectivity*, pertaining to an inappropriate display of emotion often incongruent with the patients' circumstance. In explaining the difficulty in *affectivity* Bleuler relies heavily on his ideas of associative splitting. The inclination to splitting that certain qualities of affect have the potential to possess does not occur in the healthy individual (Bleuler, 1911/1950). This is due in part by the tendency for healthy individuals to "include associatively whatever is important to the personality, if the occasion requires it" (Bleuler, 1950, p. 367).

This is not the case with individuals diagnosed with schizophrenia. The associative linkings have been weakened, resulting in those affects more likely to split off becoming unconscious after a short period of time or entirely (Bleuler, 1950). Consequently a repressive influence on the rise of other affects exists with patient appearing to be indifferent or without affect (Bleuler, 1950).

Autism is the following symptom described, a direct consequence of the individual diagnosed with schizophrenia's splitting of the psyche Bleuler (1911/1950). The bridge between reality and fantasy appears to be the focus in considering *autism* in schizophrenia, regarding a withdrawal from the social world and living in an inner world of fantasy (Bentall, 2004). This is elaborated on by Bleuler (1950) in stating that "should the external world offer him motives for his particular views, he utilizes them quite easily. Depending on the circumstances he will displace or falsify reality" (p. 373).

The last of the four A's as described by Bleuler (1911/1950) is that of *ambivalence.* As a result of the weakened associative linkings the individual diagnosed with schizophrenia does not necessarily consider bringing the aspects of a problem together (Bleuler, 1911/1950). Thus numerous concepts have for the individual "both affective signs, plus and the minus, which appear side by side, or alternatingly, one after the other" (p. 375).

The aforementioned symptoms for Bleuler (1911/1950) are the fundamental symptoms of schizophrenia. The more obvious features of the disorder such as hallucinations and delusions become accessory in that they are psychological reactions rather than the direct products of the disorder (Bentall, 2004).

From the discussion of the ideas of Bleuler one can see the enormous contribution that Bleuler brought to the field of schizophrenia. Bentall (2004) is of the opinion that Bleulers contributions were not only psychologically mindful of the disorder but also played a significant role in widening the concept of schizophrenia substantially.

Karl Jaspers. Broad conceptions of schizophrenia postulated by Bleuler emphasised the potential difficulty in determining who did and did not have the illness (Bentall, 2004). Karl Jaspers (1883- 1969) a psychiatrist who became better known as a philosopher set for himself the task of reconceptualising the manner in which psychiatrists and psychologists of the time studied mental illness. In his work in the field Jaspers thus played a great role in the

development of existential psychoanalysis (Bentall, 2004; Sadock & Sadock, 2007).

An area of interest for Jaspers was the phenomenology of mental illness, taking into account the subjective feelings of these patients (Sadock & Sadock, 2007). His ideas paved the way toward understanding the psychological meaning of the symptoms of schizophrenia including hallucinations and delusions (Sadock & Sadock, 2007).

The phenomenology of delusions was first described in the works of Jasper (1923/1963), where he noted that for delusions to be conceptualised methodologically a number of perspectives had to be taken into account. Jaspers (1963) went on to further mention that in accordance to this, from psychological performance standpoint, schizophrenia is conceptualised as a disturbance of thinking; from a psychological product perspective it is a mental creation and that from a phenomenological point of view delusions are an experience (Jaspers, 1923/1963).

There are numerous ways in which Jaspers aided in the understanding of mental illness. Bentall (2004) notes the innovative manner in which Jaspers conceptualised ideas around paranoia. Jaspers in his consideration of paranoia wondered whether it should be regarded as an abnormal form of personal development or whether it should be seen as an illness. This in itself was a novel distinction between the two possibilities. In this regard Bentall (2004) states of Jaspers ideas on paranoia that:

> If paranoia was a form of personality development it should reflect the understandable evolution of the patient's inner life. If, on the other hand, paranoia was an illness it must inevitably be considered a product of the biological changes that were presumed to accompany the onset of psychosis (p. 27).

Jaspers brought into psychiatry a biographical method, taking the illness of patients as part of their larger life history (Bentall, 2004). In using his biographical method Jaspers was able to describe the cases of paranoia he had seen with an unusual amount of detail. Through

his biographical method he was able to pay close attention to the patients' accounts of their lives before seeking treatment as well as the subjective experiences of their symptoms (Bentall, 2004).

Similar to Bleuler, Jaspers attempted to combine the biological and the psychological as seen in his work *General psychopathology* (Jaspers, 1923/1963). To better understand mental symptoms Jaspers (1923/1963) considers two methods, understanding and explaining.

Thus according to Jaspers the experience of symptoms becomes integral. In this regard symptoms are understood along the backdrop of the individual's life. In this way symptoms have meaning in the lives of patients having taken into account their life history (Bentall, 2004). Empathetic understanding of the patients' subjective experience is important for Jaspers in the psychological analysis of their abnormal experiences (Bentall, 2004).

On the other hand Jaspers (1923/1963) is of the opinion that some symptoms are of such a nature that no amount of empathy can connect understanding to the background of the patient. In these situations Jaspers (1963) is of the opinion that symptoms are caused by an underlying biological disorder.

For Jaspers (1923/1963) *Ununderstandability* becomes the hallmark of the psychoses. This becomes evident in his accounts of delusions, often expressed by psychotic patients centred generally on themes of persecution and grandiosity. In defining delusions Jaspers (1963) identifies three defining criteria for delusions; in that "(1) they are held with an extraordinary conviction, with an incomparable subjective certainty; (2) there is an imperviousness to other experiences and to compelling counter- argument; (3) their content is impossible" (p. 95). For Jaspers however the aforementioned criteria are not true determinants on whether a belief is a true delusion (Jaspers 1923/1963). Jaspers states that true delusions arise "ununderstandable because they arise suddenly without any context" (Bentall, 2004, p. 28).

Numerous other theorists played an integral role in the understanding of schizophrenia since this period. Theorists existed prior to Kraeplin and his *dementia praecox* as well as those writing during the period of *dementia praecox.* Other ideas on schizophrenia which enriched the field included Kurt Schneider and his First- Rank symptoms (Bentall, 2004). These symptoms which are distinct from second rank symptoms were all forms of hallucinations and delusions or passivity experience (Bentall, 2004). Examples of Schneider first-rank symptoms include audible thoughts, voices heard arguing, experience of influences playing on the body, delusional perception amongst a few others (Bentall, 2004).

Adolf Meyer emphasised how crucial psychological factors became in the aetiology of schizophrenia (Weiner, 1966; Wood, 2010). For Meyer life experiences were integral to schizophrenia in that the disorder was not a disease entity but rather a maladaptation which is determined by life experiences (Pao, 1979; Weiner, 1966). Thus according to Meyer the combination of faulty coping strategies and situational stress could result in a schizophrenic reaction, this he conceived as a "habit of disorganization that sometimes eventuates in pervasive personality disorganization and withdrawal" (Wiener, 1966, p. 7)

Carl Jung applied psychoanalytic concepts to schizophrenia (Weiner, 1966). His interests were in the symbolism and unconscious processes of the patient diagnosed with schizophrenia concerning themselves with the psychogenesis of schizophrenia (Weiner, 1966).

Harry Stack Sullivan spoke of the regression to infantile levels of mental functioning in describing the primary disorder in schizophrenia (Sullivan, 1974). Sullivan went on to later elaborate on his ideas of schizophrenia consisting of a critique on earlier genetic and or organic as well as psychoanalytic interpretations of the disorder (Weiner, 1966).

Sullivan's critique noted how the genetic, organic and psychoanalytic interpretations were lacking and misleading as they did not take into account the individual with the disorder

as a whole person (Weiner, 1966).

As the focus of the research is on the phenomenology of schizophrenia the theoretical conceptualisations of Jaspers and other like minded theorists becomes the focus of the schizophrenic consideration. Harland and Owen (2006) are of the opinion that succeeding the ideas of Jaspers a tradition of phenomenological psychiatry continued. Theorists involved in intensifying the relationship between phenomenology and psychiatry included amongst others Ludwig Binswanger, Wolfgang Blankenburg and Eugene Minkowski (Harland & Owen, 2006).

Phenomenology of schizophrenia. Lysaker and Lysaker (2010) are of the opinion that there need to be more first person perspectives on schizophrenia. They elaborate that although third person perspectives have greatly contributed to contemporary understandings of the disability, without a first person perspective the full picture of schizophrenia and the experience thereof remains incomplete. Additionally overlooking a first person perspective of schizophrenia could run a risk of objectifying persons with it (Lysaker & Lysaker, 2010). It is in this way that phenomenology becomes integral in the understanding of the diagnosis of schizophrenia. Phenomenology attempts to gain a greater appreciation of the first person subjective experience.

Phenomenology, psychiatry, psychology and schizophrenia. Detailing the link between phenomenology and psychopathology psychiatrist Wolfgang Blankenburg (1980b) elaborates on the phenomenological maxim "*Zu den Sachen selbst"* translated to mean "to things themselves". This maxim thus becomes an aim of phenomenological psychology as it focuses on the subjective experiences of patients removed from different schools of thought (Blankenburg, 1980b).

For Blankenburg (1980b) the goal of phenomenological psychology thus becomes the *vergenwärtigung*. This entails a more empathic view of patients where there is a heightened

sensitivity towards their experience implying openness and awareness (Blankenburg, 1980b).

In identifying the link between schizophrenia and the phenomenological perspective Rulf (2003) identifies a number of essential dimensions. The phenomena of *autism, common sense, intersubjectivity* and *ipseity* (mineness) become the essential dimensions of schizophrenia (Rulf, 2003). The commonality of these phenomena thus becomes concerned with the person in relationship to the self, others and the world (Rulf, 2003).

Swiss phenomenological psychiatrist and psychoanalyst Ludwig Binswanger in his commentary on the link between schizophrenia and phenomenology identifies what he calls the *existential failure* which becomes representative of the person diagnosed with schizophrenia's world (Binswanger, 1956). *Existential failure* refers to the process of one being static in their life characterised by extravagance, perverseness and manneristic behaviour (Binswanger, 1956). The aforementioned characteristics of *existential failure* for Binswanger (1956) correspond respectively to the areas of psychopathology concerned with rigidity, stupor and splitting.

Extravagance for Binswanger (1956) is regarded as an exaggerated or extravagant notion of an ideal existence. Perverseness on the other hand pertains to the identification of the world in a manner that is contrary to how it is. This is often characterised by an 'arrest' of the person diagnosed with schizophrenia's self realisation. In this regard the world is viewed as disconnected and distorted, where the future is viewed as unattainable and removed from their self concept (Binswanger, 1956).

Psychopathological and existential accounts of schizophrenia for Binswanger (1956) vary in their understanding of the term splitting. In psychopathology the term splitting pertained to the loss of associative connections (Barlow & Durand, 2009; Sadock & Sadock, 2007; Weiner, 1966). Conversely the loss of a personal quality and uniqueness to an individual's existence is characteristic of splitting from an existential point of view

(Binswanger, 1956).

For Binswanger his interests lay in existential philosophy with his contributions linking existential thought and schizophrenia. Binswanger' contributions thus allow for a greater understanding on the person diagnosed with schizophrenia's experience and the different modes of being.

Contributions to the field of phenomenology and psychiatry have opened up different ways of understanding and conceptualising forms of psychopathology. From an array of perspectives phenomenological contributions to the field of schizophrenia have taken to account the subjective experience of patients. Psychiatrist Eugene Minkowski's contribution aimed at trying to better understand the nature of the condition. His contribution focused on a number of facets including spatial thought and disordered thinking in addition to the person diagnosed with schizophrenia's contact with reality.

Influenced by the ideas of Henri Bergson, a French phenomenological philosopher, Minkowski (1927) proposed the concept of a *loss of vital contact with reality*. This concept stemmed from the writings of Bleuler and the *autism* concept. According to Wood (2010) the *loss of vital contact with reality* becomes an appropriate representation of the "schizophrenic's autistic relationship with reality" (p. 17).

For Minkowski (1927) the vital contact with reality is at the very core of our personality. Vital contact with reality thus links people to the world which they live in. A harmony thus exists between ourselves and reality, allowing us to be a part of the world whilst views held in our own lives are preserved (Minkowski, 1927). The *loss of vital contact with reality* appears to be linked for Minkowski (1927) with the irrational factors of life. Loss thus stems from a disruption in the irrational feeling of harmony between the world the normal subject experiences and oneself (Wood, 2010). For Minkowski (1927) intelligence is characterised by constant reconstruction incapable of recapturing something new, whereas

pragmatic aspects concern it with more dynamic considerations. A harmonious interaction thus exists between these two aspects insofar as solitarily they have an inability to account for existence. Minkowski (1927) explains this poignantly when saying "together they are complementary while at the same time limiting the other's sphere of influence in an entirely natural and appropriate way" (Minkowski, 1927, p. 194).

Thus in terms of the experience of the person diagnosed with schizophrenia Minkowski is of the opinion that they engage with the world insofar on an intellectual level. In this manner they are in a constant state of reconstruction, with an inability to experience something new. In this regard disharmony exists between the intellectual and the pragmatic aspects of existence (Minkowski, 1927). As a result of the disharmony which exists in the person diagnosed with schizophrenia, Wood (2010) notes that the force that ties the personality thus becomes quite compromised.

Literature on the experience of positive symptoms. Research on schizophrenia according to Corin and Lauzon (1994) centred around the vulnerability model of schizophrenia, focusing on the risks and protective factors, rather than the identification of the experiences of these individuals. These authors are of the opinion that a better frame of reference is needed that it "defines the very notion of experience, especially in relation to psychiatric disorders, and that critically examines the possibilities and limits of a direct understanding of the other's world" (p. 5).

Literature has diverse accounts on the experiences of individuals with schizophrenia (Chinn, Drinnan & Hayward, 2009; Martens, 2010; Suri, 2011). In his exploration on psychosis and language Martens (2010) states that a delusion can also be adaptive in that a person's own experience thereby create a sense of security and order.

Suri (2011) argues that few authors have considered the possible function of meaning, of auditory hallucinations experienced by individuals with schizophrenia. Contrary to previous

research she is of the opinion that auditory hallucinations are not figments of the imagination but rather there is symbolic message for these individuals through the experience.

She further notes that for individuals who have ascribed meaning to their auditory hallucinations there are several implications. First, they may find insight from their auditory hallucinations and secondly auditory hallucinations serve purpose or a function in their everyday lives. Lastly if meaning is ascribed to auditory hallucinations, they possible hold value for individuals experiencing them (Suri, 2011).

Chin et al. (2009) focused on how persons diagnosed with schizophrenia relate to their auditory hallucinations. In relating to the auditory hallucinations there appears to be interplay between the voice hearer and the voices heard. The experiences of hallucinations over the past two decades have come to be understood as experiences permeating in meaning. Henceforth there has been a shift in therapeutic approaches; moving away from symptom eradication to exploring personal meaning in an attempt to restructure the possible distress (Chin et al., 2009).

Denial of mental illness. Due to a number of variables patients diagnosed with a mental illness may exhibit poor insight into their current condition (Langdon & Ward, 2009). According to them three factors play a role in the lack of awareness of illness; namely poor insight, denial of good commonsense and what they deem to be the dismissal of the obvious.

According to Amador, Gorman, Strauss and Yale (1991) a number of terms have been used in the description of persons diagnosed with schizophrenia's unawareness of their current condition. Terms they mention include; poor insight, sealing over, defensive denial, indifference reaction, evasion and external attributions.

According to Langdon and Ward (2009) there are two perspectives that have attempted to understand the aetiology to the lack of awareness in persons diagnosed with schizophrenia. The deficit approach postulates that there is a lack of awareness and poor

insight on the part of the person diagnosed with schizophrenia as a result of the loss of neuropsychological ability. The second perspective, the nondeficit approach postulates that persons diagnosed with schizophrenia are able to have insight into their illness however to acknowledge negative parts of themselves would be too threatening to their sense of self and thus avoid this distress (Langdon & Ward, 2009). According to them support for the nondeficit approach is given further weight by the lack of insight in persons diagnosed with schizophrenia being clinked with a greater need for positive approval, escape-avoidance strategies as well as self self-defensive attributional biases.

Amador et al. (1991) are of the opinion that in understanding the lack of awareness in persons diagnosed with schizophrenia different frameworks needs to be considered. Thus poor insight is deemed as a psychological defense at one end of the spectrum, at the other end poor insight implies a cognitive deficit.

Culture and schizophrenia. Several definitions exist for the concept of culture (Al-Issa, 1995) consisting of both objective and subjective characteristics. Objective aspects of culture include the physical environment such as artefacts, whereas subjective characteristics include the "beliefs, values, norms and myths shared by the group and symbolically transmitted to its members from one generation to another" (p. 3).

According to Sadock and Sadock (2007) culture has the distinctive ability to join "the objective world of perceived reality to the subjective world of the personal and intimate lends it its powerful role as expressor, mediator and moderator of psychological processes and, ultimately, emotional disorders" (p. 169). The role culture plays with regards to psychological processes is important to consider in the potential diagnosis of schizophrenia

Culture bound syndromes and ukuthwasa. According to Bentall (2004) there is evidence of a cross cultural difference in the manifestation of psychosis. A previous discussion on the bizarre quality of delusions aimed to demonstrate the potential difficulty of

deemed abnormal and normal behaviour along this back drop of culture.

Similarly Karp (1985) is of the opinion that in cross cultural studies the boundary between normal and abnormal becomes difficult to place. This difficulty becomes amplified when psychiatric diagnoses are taken into account. In his discussion on hallucinations and their manifestations in different cultures Bentall (2004) suggests that:

> Cross-cultural differences in hallucinatory experiences reflect culturally embedded beliefs about the boundaries between imagination and reality, so that experiences that would be regarded as imaginary in one culture are regarded as real in another (p. 133)

Bentall (2004) is thus of the opinion that in failing to appreciate the cultural context of hallucinations and or delusions clinicians are prevented from appropriately reacting to the experienced distress. It is in this regard that one considers culture bound syndromes and their manifestations over different cultures.

Culture bound syndromes according to DSM-IV-TR (2000) denote "recurrent, locality- specific patterns of aberrant behaviour and troubling experiences that may or may not be linked to a particular DSM-IV diagnostic category (p. 844). Sadock and Sadock (2007) further notes how culture bound syndromes appear to fall outside of Western psychiatric categories. Culture specific traits are seen as the influence in the formation of these syndromes (Jilek & Jilek- Aall, 1985). The cultural assumptions of local inhabitants according to Sadock and Sadock (2007) inform cultural traits. Various cultural assumptions exist over a wide array of cultures including witchcraft and sorcery, disease intrusion or the breach of taboo (Bentall, 2004; Sadock & Sadock, 2007).

Parzen (2003) notes how by the late nineteenth century, ethnographers and missionaries had documented encounters with individuals exhibiting peculiar symptoms of psychological distress. Subsequent researchers and ethnographers placed various labels on these symptoms including psychogenic psychoses, ethnic psychoses, exotic psychoses and

culture reactive syndromes (Bhugra, Siribaddana & Sumathipala, 2004; Parzen, 2003).

Atypical culture-bound psychogenic psychoses as a term however originated with Pow Meng Yap a pioneer in transcultural psychiatry (Guarnaccia & Rogler, 1999; Jilek & Jilek- Aall, 1985; Parzen, 2003). Yap (as cited in Bhugra, Siribaddana & Sumathipala, 2004) recommended that various terms used to describe these syndromes be described as 'atypical culture-bound psychogenic psychoses', to be subsequently abbreviated to 'culture-bound syndromes'.

Conditions noted for this diagnosis included *koro, latah* and *amok* where Yap noted a dominant influence of cultural traits in the formation of these conditions (Jilek & Jilek- Aall, 1985). A number of culture bound syndromes exist from both Western and Eastern cultures, of these *koro, latah, amok* and *dhat* have been well documented (Bhugra, Siribaddana & Sumathipala, 2004; Jilek & Jilek- Aall, 1985).

Koro refers to an illness where individuals experience sudden and intense anxiety that the penis will recede into their body which will inevitably lead to their death (Bentall, 2004; Guarnaccia & Rogler, 1999; Jilek & Jilek- Aall, 1985; Karp, 1985). *Koro* has also been identified in females where intense anxiety centres on the vulva and nipples receding into the body (Sadock and Sadock, 2003). This syndrome is reported in South and East Asia where it is known by a variety of names (Sadock & Sadock, 2003). According to Jilek and Jilek- Aall (1985) instances of *koro* are usually brought on by stressful experiences. These experiences include unexpected losses, bad dreams or the failure to observe taboos (Jilek & Jilek- Aall, 1985).

Jilek and Jilek- Aall (1985) note how *koro*-like symptoms appear to have been identified away from South and East Asia, in Western populations (Jilek & Jilek- Aall, 1985; Sadock & Sadock, 2003). Jilek and Jilek- Aall (1985) note how these symptoms have been found in a variety of psychiatric populations including German bipolar patients and American

patients diagnosed with schizophrenia. As culture bound syndromes are evident across the globe, Africa and more pertinently South Africa has its own deliberation where the practice of psychology and indigenous healing illnesses come together.

In South Africa an overlap exists between the practice of psychology and indigenous healing illnesses (Dalasile et al., 2011). According to Dalasile et al. (2011) illnesses frequently treated by indigenous healing methods include depression, anxiety disorders, psychosomatic disorders and schizophrenia. The illnesses commonly identified and examined in South African literature are *amafufunyana* and *ukuthwasa* (Dalasile et al., 2011). The healing sickness noted among the Xhosa and Zulu is known as *ukuthwasa* which is interpreted as a calling from ancestors to become a traditional healer (Booi, 2004; Dalasile, 2011; Flisher, Sorsdahl, Stein & Wilson, 2010; Zabow, 2007).

According to Flisher et al. (2010) prior to the period of spirit possession individuals are inflicted with a mental disorder in heeding the calling from ancestors to become a traditional healer. This is known as being called for *ukuthwasa*. *Amafufunyana* unlike *ukuthwasa* is an illness caused by witchcraft where an individual is possessed by evil spirits (Dalasile et al., 2011; Flisher et al., 2010; Zabow, 2007). It is also believed that *amafufunyana* is the consequence of a number of other factors, including substance abuse, living in poverty, relationship and family problems or the will of God (Flisher et al., 2010; Zabow, 2007).

Thus *amafufunyana* and *ukuthwasa* appear to be on opposite ends in the cause of spirit possession. Dalasile (2011) argues this point in noting the disparity between the two when stating that *amafufunyana* is viewed as a "negative state of possession and is associated with mental disorder" (p. 92) whereas *ukuthwasa* "refers to a more positive state of spirit possession emanating from the emotional turmoil that follows the calling to someone by the ancestors to become a traditional healer" (p. 92).

Spirit possession being a part of an individual's path to becoming a traditional healer is seen in other African countries. Traditional healers in Uganda and Tanzania are seen to take up their vocations as healers through the symptomatic experience of psychotic episodes (Bentall, 2004). Among the Xhosa and Zulu symptoms of *ukuthwasa* manifest themselves in different ways with the onset of misfortune and illness interpreted as the calling (Booi, 2004; Zabow, 2007). Booi (2004) notes the array of symptoms, ranging from aggression and aimless wandering to anxiety, mental confusion and social isolation. Auditory and visual hallucinations as well as delusions are also seen as symptomatic of the calling with the constant feature being excessive dreaming (Booi, 2004).

The symptoms of both *amafufunyana* and *ukuthwasa* are similar to those of schizophrenia (Dalasile, 2011). Similar symptoms include auditory and visual hallucinations in addition to the delusions. If the symptoms do not dissipate after answering the calling Booi (2004) notes how what was initially thought to be *ukuthwasa* is in fact *ukuphambana*. *Ukuphambana* is the Xhosa term for madness (Booi, 2004; Zabow, 2007) referring to a person who appears to have gone insane. Individuals with *ukuphambana* may be referred for treatment at a psychiatric hospital (Booi, 2004).

Debate rages on whether *amafufunyana* and *ukuthwasa* should be considered as culture bond syndromes (Dalasile, 2011). Central to this debate is the implicit given assumption that these syndromes deviate from 'western disorders' (Dalasile, 2011). According to Bentall (2004) Western psychiatrists have on occasion attempted to account for culture-bound syndromes. The argument states that mental disorders remain constant across cultures, and that culture bound syndromes become "locally shaped expressions of disorders that are universal" (Bentall, 2004, p. 131).

Healing, religion and psychosis. Washington (2010) notes how the word Zulu is directly related to God's people or people from heaven. With this in mind God becomes

central and that Zulu people are heavenly. Healing in Zulu is centred around *uMvelinqangi* (God), *amadlozi* (ancestors), as well as the connection to these spiritual forces. This person according to Washington (2010) is known by the West as a traditional healer.

Washington (2010) speaks of psycho-spiritual disorders rather than mental disorders. This being due to the manner in which Zulu people conceptualise psychological problems. Thus illnesses addressed by traditional healers, illnesses are put in order on the basis of their causality (Washington, 2010). "One category of disease is *umkuhlane* (illnesses of a natural cause). Included under this category are *isithuthwane* (epilepsy), *isifuba somoya* (asthma) and *ufuzo* (familial/genetic disorders) such as *isidalwa* (mental retardation) and *uhlanya* (schizophrenia)" Washinton, 2010, p. 6).

Makhanya (2012) notes that Washington (2010) sees schizophrenia as having a genetic component. Booi, 2004; Dalasile, 2011; Flisher, Sorsdahl, Stein & Wilson, 2010 and Zabow, 2007, are of the opinion that these symptoms will arise either from not taking up calling as a traditional healer or having been bewitched.

According to Hedden, Stetz and Webb (2008) although Christian denominations support psychological or medical explanations for mental disorders, some are of the opinion that mental disorder can be explained as " reflection of one's alienation from God, or as a sign of demonic possession" (p. 698). They further state that some denominations are of the opinion that by virtue of their faith this protects them from mental illness. Hedden et al. (2008) further report that conservative groups may turn to prayer as a means to cure mental illness.

Literature on schizophrenia and culture. The nature of the symptoms of schizophrenia across cultures has been of prominent interest for a number of years (Carter & Neufeld, 1998). A literature review conducted in the late 1960's showed the universality of schizophrenia with different patterns in different cultures (Carter & Neufeld, 1998).

These patterns included a higher prevalence of auditory hallucinations amongst patients from Western cultures (Carter & Neufeld, 1998). Furthermore the affect of African patients had been observed as appearing more blunted than their Iranian and Italian counterpart's, and lastly African patients appeared to display lesser levels of violence (Carter & Neufeld, 1998). Amongst indigenous cultural groups in South Africa psychotic symptoms can be attributed to spiritual forces (Asmal, Kritzinger, Mall & Swartz, 2011; Calitz, Louw & Mosotho, 2011; Kajee, 1985).

Kajee (1985) in his study on auditory hallucinations amongst psychotic Indian males from Durban South Africa is of the opinion that cultural norms dictate the manner in which individuals will experience hallucinations. This Kajee (1985) states is highlighted in cultures where there is a belief in the supernatural:

> In many cultures in which people believe in the existence of another or supernatural world and in which people after death are supposed to enter this other world, hallucinations are regarded as a means of communication with this supernatural world. In these cultures people who are hallucinated are often regarded as especially favoured by the gods and they are consequently accorded respect and esteem or are regarded with awe and dread by their fellow men. Conversely, they may be thought to be attacked by evil powers and thus considered to be in need of support, sympathy and defence (p. 8- 9).

Calitz, Louw and Mosotho (2011) in their study on the clinical presentation of schizophrenia among Sesotho speakers in South Africa, make mention of vital cultural elements. Similar to the ideas of Kajee (1985) this ethnic group also presented with delusions of the supernatural with persecutory delusions of this population centred on bewitchment.

The cultural belief in the supernatural has also been identified in the manifestation of visual and olfactory hallucinations among the Sesotho speakers diagnosed with

schizophrenia. The themes identified centred on ancestors; whether it was in seeing ancestors, hearing ancestors or in smelling the traditional medicine, *muti* (Calitz, Louw & Mosotho, 2011).

Mental illness in black communities can also be due to "ancestral wrath and the failure to honour cultural practice" (Fisha, 2001, p. 28). In these instances what has been found as a cure are traditional healers. Thus traditional healers are tasked with reversing the misfortune bestowed on these individuals (Fisha, 2001).

Historically research on schizophrenia identified its existence over cultures. Some researchers note however the lack of commonality in methodological approaches making the comparisons over different cultures difficult to identify (Calitz, Louw & Mosotho, 2011). Culture plays a key role in the development, presentation, course, and outcome of psychopathology such that "culture plays an important and integral part in the total development and expression of personality and behaviour" (Calitz, Louw & Mosotho, 2011, p. 50).

Thus the impact that culture has on what is perceived as normal behaviour, can also be identified in abnormal behaviour. Furthermore culture not only influences what is regarded as normal and abnormal, it also influences the experience and expression of abnormal behaviour.

The clinical features of schizophrenia may differ from culture to culture. Thus culture as a variable, in addition to different diagnostic criteria has caused much debate around the clinical picture of schizophrenia. Similar to research stated in Carter & Neufeld (1998), Calitz, Louw and Mosotho (2011) identified the comparison between Western and African patients diagnosed with schizophrenia. In their reporting they noted that Western patients appear to experience more auditory hallucinations, whereas patients from the rest of the world, and more so in Africa experience more visual hallucinations.

In their study on Xhosa-speaking patients diagnosed with schizophrenia and their experiences of their mental illness Crick and Swartz (1998) note the steady increase in the understanding of the cultural dimension of psychiatric illness. They explain how since the late 1980s the understanding of culture has steadily increased. These researchers argue that through continued research there have been documentations of specific experiences of psychiatric patients and that research will further develop the understanding of cultural differences (Crick & Swartz, 1998).

Amongst the psychotic disorders schizophrenia stands out as the most debilitating of these disorders. Negative and positive symptoms exist which are characteristic of this disorder, which for this study an identification of the positive symptoms of hallucinations and delusions will be made. Schizophrenia has been identified historically by a number of theorists who in their consideration have detailed different aspects of the disorder. Details of the disorder include the cognitive aspects of the disorder as well as classification systems within the disorder.

The phenomenology of schizophrenia has been considered by several theorists who had as a goal an understanding of the experience of the disorder. Personal accounts from individuals who are diagnosed with the schizophrenia and literature on the perceived experience of psychosis assist in a greater understanding of schizophrenia from a phenomenological viewpoint.

From a cultural perspective schizophrenia and the symptoms of it can be seen from various aspects. Theoretically symptoms of schizophrenia can be identified as falling under the realm of culture bound syndromes. Culture-bound syndromes are present all over the world across different languages and cultures. *Amafufunyana* and *ukuthwasa* symptoms may be seen as similar to the positive symptoms of hallucinations and delusions. This becomes quite difficult as there may be danger in the misdiagnosis of individuals.

Family relationships and schizophrenia. Adams, Dixon & Lucksted (2000) are of the opinion that families are able to provide a considerable amount of support to family members diagnosed with schizophrenia. With this however they may come some burdens of supporting the family member. Persons diagnosed with schizophrenia may thus dependant on family members for financial and emotional support. As a result of this the quality if the relationship has an impact on the family's well being (Adams et al., 2000).

The different types of support provided by family members to members diagnosed with schizophrenia may also have an effect on their own general and mental health. This burden according to Grandón, Jenaro & Lemos (2008) refers to the negative impact of the family members' mental disorder on the rest of the family.

Objective and subjective dimensions of burden were identified by researchers in the 1950s with regards to families with persons diagnosed with schizophrenia (Angermeyer, Dietrich, Jungbauer & Wittmund, 2004). Objective burdens referred to the observable cost to the family due to diagnosis; such as financial expenditure for their treatment as well as the disruption that this may cause. Subjective burden refers to the persons subjective experience of their diagnosis and impairment as well as to the degree they find their impairment difficult.

A significant amount of research has gone into the burden faced by families with persons diagnosed with schizophrenia. Angermeyer et al. (2004) are of the opinion that not enough attention has been paid to on the living situation of spouses of persons diagnosed with schizophrenia. They postulate that the reason why there is little research on the spouses is because the family of origin is still considered the most central social contact for a great deal of persons diagnosed with schizophrenia (Angermeyer et al., 2004).

Clark, Lubman & McCann (2011) identify the caregiver's experience of caring for a young adult with psychosis. They are of the opinion that caregivers in this regard are faced with three challenges; the struggle to be a caregivers, being a parent as well as still having to

maintain the family unit. Similar to Adams et al. (2000), Angermeyer et al. (2004) and Grandón et al. (2008) this may become a burden for the caregiver and they make experience financial difficulties.

Parents experience an array of emotions in trying to better understand what is happening to their children. Feelings range from guilt, helplessness and the regret that they should have sought out treatment earlier, mistaking psychosis for what is perceived to be normal adolescent behaviour. Furthermore parents may begin to grieve; grieving the loss of their child who had not previously been diagnosed with a psychotic illness (Clark et al., 2011).

Conclusion

In this chapter a review of the literature was conducted taking into account gender, development, culture and schizophrenia, within the context of the research. Throughout the different perspectives considered a critical consideration was taken into account. This consideration focused on a Western perspective and then that of an African perspective, more so within the South African perspective.

A gender perspective was reviewed defining sex and gender in addition to understanding gender differences from two psychological theories of gender. The two chosen theories; from the biosocial perspective and evolutionary psychology theory allow one to better understand the formation of gender norms and stereotypes.

In the development perspective the focus was on adulthood. Erikson's theory on human development was considered as well as a contemporary understanding of emerging adulthood. The last aspect of development considered was adulthood in the South African context. A rite of passage needs to be completed for young girls and boys in certain cultures in South Africa, after which they emerge as adults.

Culture, ethnicity and South Africa were also reviewed. In this regard definitions of

culture and cultural identity and ethnicity were explained. In the context of South Africa, a culture rich in diversity a number of contextual descriptors of the country were detailed. Contextual descriptors included the estimated number of the entire population of South Africa, the different ethnic groups that exist in the country as well as an identification of the languages spoken in the country. As the research participants are Zulu, contextual descriptors of the Zulu ethnic group were identified including customary practice, language and aspects which make the Zulu different from that of other ethnic groupings.

Schizophrenia was also reviewed in this chapter. The focus of this review focused on the definition of schizophrenia, a historical detailing of theorists who have previously identified the disorder as well as the phenomenology of the disorder. Similar to the developmental perspective, a cultural perspective of schizophrenia was reviewed. This review had as its focus culture-bound syndromes as well as symptoms of *ukuthwasa* and *amafufunyana.* Along the lines of this investigation a cultural perspective becomes important as there appears at times great divide in Western and African thinking on certain aspects. This was noted in the review concerning the developmental perspective, culture and ethnic identity as well as the cultural elements of schizophrenia.

It is often quite difficult to place within the literature review all information available on certain phenomena. It is thus in our literature reviews as researches that information chosen is selected in relation to the phenomenon under investigation. With regards to this investigation information chosen for the literature focused on a number of elements. Firstly gender and sex were noted as participants for the study are male. Secondly a developmental perspective was considered as the males chosen for the study are adults.

In the distinction of young and older adults one begins to critically understand the notion of being at this stage of one's human development. Culture, ethnicity and the notion of being Zulu was reviewed as participants chosen for the study are Zulu. Lastly schizophrenia

was reviewed from a number of domains in relation to the phenomenon under investigation. The participants for the research have been diagnosed with schizophrenia, secondly the experience of these individuals becomes crux of our investigation thus the phenomenology of the disorder was reviewed.

Chapter 3: Theoretical Framework

Introduction

In this chapter the theoretical underpinnings for the research will be discussed. It is important to ground research in theory because it is a platform for the research method and methodology and specifically interpretative phenomenology.

The theoretical framework for this research is phenomenology and more specifically interpretative phenomenology. There is a number of different phenomenology approaches each with their own epistemological assumption. The two major approaches will be introduced with a detailed discussion on interpretative phenomenology. Phenomenological research on schizophrenia will also be explored.

Phenomenology

Dowling (2007) notes how the term phenomenology appears to be accompanied by uncertainty when considering its nature. Because not only is phenomenology a research method used by qualitative researchers for it is also a philosophy (Dowling, 2007; Swanson & Wojnar, 2007). In this section phenomenology will be considered taking into account its philosophy, the different types of approaches as well as the main proponents.

Smith (2011) defines phenomenology as being the study of phenomena identifying the meaning things hold in our experience. The term phenomenology was used in philosophical texts in the 18th century (Dowling, 2007; Smith, 2011). At the time phenomenology meant the theory of appearances which were fundamental to empirical knowledge (Smith, 2011). During this time more and more philosophers began to use the term in their writings.

According to Smith (2011) the latin term *Phenomenologia* was introduced by Christoph Friedrich Oetinger in 1736. After this the German term *Phänomenologia* was used

by Johan Heinrich Lambert. Other philosophers who used the term include Immanuel Kant, Johann Gottlieb Fichte and G.W.F Hegel (Smith, 2011). Towards the latter part of the nineteenth century Franz Brentano used the term to note what he called descriptive psychology. It was from this that Edmund Husserl brought about his ideas for his new science of consciousness (Dowling, 2007; Smith, 2011).

The philosophical tradition of phenomenology was propelled forward in the first half of the 20th century by Edmund Husserl, Martin Heidegger, Maurice Merleau-Ponty and Jean-Paul Satre (Dowling, 2007; Smith, 2011). These individuals had different conceptions of phenomenology and the different approaches, epistemologies and ontologies.

Phenomenology has its origin with the works of Edmund Husserl. He had at the core of his consideration the human experience, noting the need to return to the grounding of what is true through these experiences (Caelli, 2001). Husserl's ideas inspired further development in phenomenology and subsequent phenomenological writing. Phenomenological approaches had their own unique perspectives and similarities (Harder & Norlyk, 2010; Swanson & Wojnar, 2007). Two of the prominent approaches include descriptive or transcendental constitutive phenomenological approach and the interpretive or hermeneutic phenomenological approach (Harper, 2012).

The field of phenomenology is broad. As mentioned above there are two prominent approaches to phenomenology. According to Smith (2011) the broad range of phenomenology is seen by identifying the seven types of phenomenology. These include; transcendental constitutive phenomenology, naturalistic constitutive phenomenology existential phenomenology as well as generative historicist phenomenology (Smith, 2011). Genetic phenomenology, hermeneutical phenomenology and realistic phenomenology are included in the broad types of phenomenology.

Descriptive and hermeneutic phenomenology. As mentioned previously a number

of authors launched the tradition of phenomenology in the early 20th century. Of these the main proponents are Edmund Husserl and Martin Heidegger (Swanson & Wojnar, 2007). Their different perspectives locate themselves in different paradigms such that the works of Husserl fall into the positivist paradigm and Heidegger's work falls into the interpretivist paradigm (Dowling, 2007). In the following section a detailed understanding of these main proponents will be discussed taking into account the key elements as well as the differences and similarities.

Descriptive phenomenology as proposed by Husserl is concerned "with how objects are constituted in pure (transcendental) consciousness" (Swanson & Wojnar, 2007, p. 173). According to these authors descriptive phenomenology is able to do this by restricting ones ideas on the phenomena being observed.

According to Lopez and Willis (2004) an assumption specific to Husserlian philosophy is that experiences as perceived by human consciousness do have value and thus should be studied. For Husserl information gained that is particular to an individual's experience was considered to be of importance to scientists seeking to understand human motivation. And in this manner illustrating how human action is influenced by ones perception of what is real (Lopez & Willis, 2004).

Husserl was motivated by the ideas of Franz Brentano (Dowling, 2007). He utilised Brentano's account of intentionality as a concept in understanding ones conscious acts and experiential mental practices. In applying intentionality Husserl supposes that every mental act that is done is related to an object (Dowling, 2007).

Husserl presented an ideal of descriptive subjectivity in his later works (Lopez & Willis, 2004; Swanson & Wojnar, 2007). This relates to the process where the researchers can effectively abandon their own lived reality in an attempt to describe phenomenon in its purest form (Swanson & Wojnar, 2007). Zahavi (2003) describes the procedure of

abandoning one's own reality to describe the others reality in its purest form as epoché.

Descriptive subjectivity can be accomplished by using the process of bracketing (Lopez & Willis, 2004; Swanson & Wojnar, 2007). Bracketing is a process by which one consciously and actively aims to distance oneself from prior knowledge and personal bias. In this way they do not influence the description of the phenomenon (Swanson &Wojnar, 2007). Thus descriptive phenomenology employs methods like bracketing in order to describe the lived experience of the other. Epoché is the procedure used in order to describe the experience of the other without "unnecessary" interference. Therefore epoché is a process of managing pre-understandings, preconceived ideas, assumptions or perceptions. Descriptive phenomenology thus is rather rigid in its aim to be an unbiased research method.

According to Swanson and Wojnar (2007) there is a process by which bracketing takes places. Firstly one needs to separate the phenomenon at hand from the world and dissect it. Secondly in dissecting the phenomenon the structure becomes unravelled, defined and analysed. Lastly one needs to suspend all prior concepts regarding the phenomenon and looking at it on its own terms. Researchers applying a more descriptive approach would thus abandon their thoughts on a given phenomena and try to better understand what the phenomena mean for participants.

Husserl and the descriptive school propelled forward the notion of subjective experience and the need for this to be scientifically investigated. In applying descriptive subjectivity through the process of bracketing one can describe phenomena free of bias. The other leading phenomenological approach had differing ideas to Husserl and descriptive phenomenology. The interpretive approach will be detailed in addition to identifying the similarities and differences between the two schools.

The interpretive (hermeneutic) phenomenological approach is concerned with interpretation of experiences as well as how these experiences are understood for the people

who live them and those who study these experiences (Swanson & Wojnar, 2007). This approach is also most closely associated with Heidegger.

Interpretive phenomenology has at its core the understanding of individuals, an all encompassing understanding that cannot occur in isolation, such that cultural and social contexts are integral in the appreciation of the individual's unique experience. It is thus important to consider the roots of this paradigm and the ways in which the experiences of people are understood.

Nieuwenhuis (2007) notes interpretivism's roots in hermeneutics, the study of the theory and practice of interpretation. The development of interpretivism as a philosophical theory began in the 19th century, with a number of followers within this school of thought. Followers of this paradigm were concerned with conceptualising understanding. Furthermore they were interested in the diverse manner of considering one's experience.

Hermeneutic theorists Dilthey and Schleiermacher regarded understanding to be a process of psychological reconstruction by which "the reader reconstructs the original intention of the author" (Nieuwenhuis, 2007, p. 59). Theorists Gadamer and Heidegger took a different stance within the interpretive school of thought with the realisation that knowledge is not absolute (Nieuwenhuis, 2007). All four theorists were concerned with the subjective understanding of individuals where Gadamer and Heidegger further noted that meaning can continually be generated.

Where Husserl had as his focus the description of phenomenon Heidegger placed more emphasis on understanding (Dowling, 2007). This understanding for Heidegger occurs through understanding. Heidegger believed that humans are hermeneutic, thus interpretive. People are capable of finding meaning in their own lives (Swanson & Wojnar, 2007).

Therefore a person gains understanding and meaning through interpretation which is a subjective process. Therefore both descriptive and interpretative phenomenologies are

interested in studying people's experiences, people's subjectivities. But they differ significantly on their views on the researcher's subjectivity and what role it should, or should not play.

Heidegger introduced the concept *dasein*, a way of being in the world (Swanson & Wojnar, 2007). He did this in order to highlight the difficulty in abstracting oneself from various context which give meanings to ones experience. The assumptions of *dasein* or situatedness are the fundamental aspects for preunderstanding (Swanson & Wojnar, 2007). Preunderstanding was also termed by Heidegger as the forestructure of understanding comprised of three elements; fore-having, fore-sight and fore-conception.

Fore-having refers to the familiarity of a phenomenon (Swanson & Wojnar, 2007). In that all individuals approach situations with a level of familiarity, dependent on experiences in their own lives. The practical familiarity through which one looks at these experiences is for Heidegger what makes interpretation possible (Smith 2007).

The second of these elements is fore-sight where socio-cultural background provides a backdrop from which to make an interpretation. The last of the elements fore-conception takes into account the socio-cultural background which provides a basis for what is to be anticipated in a phenomenon (Smith, 2007). Fore-sight and fore-conception appear quite similar as they both take the socio-cultural background into account when making an interpretation. These two elements differ as fore-sight considers only ones socio-cultural background as a means of making an interpretation whereas in fore-conception an interpretation is made but during this encounter one cannot help but drawing on one's own prior experiences (Smith, 2007; Swanson & Wojnar, 2007).

The interpretive approach is thus concerned with the manner in which people make meaning for themselves. Phenomena are experienced through forestructure, identifying ones socio-cultural background and past experiences which shape present experiences.

From the two described major approaches of the phenomenological tradition there appear to be overlapping similarities and distinct aspects which make them unique. Fundamentally both the interpretive and descriptive schools emphasise the importance of understanding the lived experience of individuals (Swanson & Wojnar, 2007).

According to Smith (2011) there are several differences between the two schools. The first of these is the fundamental premise of each school. Where Husserl and the descriptive school have as their emphasis the describing of universal essences, Heidegger and the interpretive school are concerned in understanding the phenomena in perspective. Secondly the descriptive school views an individual as one representative of the world, whereas the interpretative school considers individuals to be self-interpretive beings (Swanson & Wojnar, 2007).

With regards to what is shared amongst individuals, the descriptive school is of the opinion that consciousness is what is shared while the interpretive school is of the opinion that "contexts of culture, practice, and language are what humans share" (Swanson & Wojnar, 2007, p. 175). The descriptive school supposes that it is only once we have stripped ourselves away from prior knowledge about phenomenon then only can one present on phenomena free from bias. The interpretive school differs on this stating that by being pre-reflexive beings researchers become actively engaged in co-creating interpretations of phenomena (Smith, 2007). Therefore in the interpretative approach free, objective accounts of someone's experiences are impossible.

The descriptive school aligns itself with established scientific rigor so as to certify description of universal essences (Dowling, 2007). The interpretive school on the other hand, is of the assumption that there is a need to establish contextual criteria for dependability of different interpretations of phenomena. The last of the differences between the two schools centres on interpretation. Where the descriptive school assumes that bracketing is used to

make certain that interpretations are free of bias, the interpretive school is of the opinion that pre-understanding and double hermeneutics, ones understanding of the other's understanding, between the researcher and their participants is what makes interpretation meaningful.

According to Harper (2012) a phenomenological framework often appeals to psychotherapeutically inclined researchers. This is due to phenomenology's interest in the nature of subjective experience and therefore the focus becomes on how clients subjectively experience the world. The focus becomes not on the accuracy of what is said by clients; but rather putting focus on understanding what is said from their perspective (Harper, 2012).

In terms of the theoretical stance from which schizophrenia is understood, as well as the methodology underlying the research method and process, a phenomenological positioning is taken. More specifically this research project aligns itself with the interpretive perspective of phenomenology. Therefore the socio-cultural background of both participants and researcher will be considered in detail. Furthermore in making interpretations more meaningful during the research project considering the pre-understanding of both researcher and participants may bring with it possible insights. This will be undertaken through the process of reflexivity which will be detailed in chapter five.

Phenomenology and schizophrenia. Phenomenology has at its core the understanding of the lived experience of individuals. Furthermore a link appears to exist between phenomenology and psychopathology given that the lived experience of individuals diagnosed with a mental disorder has been researched in order to better understand psychopathology. Psychopathology is the study of psychological disorders (Barlow & Durand, 2009; Sue, 2010). In this section the link between phenomenological research and conceptualisations and schizophrenia will be detailed.

According to Rulf (2003) there is an overlap between the fields of psychopathology and psychiatry. Whereas psychopathology concerns itself with psychological disorders,

psychiatry also concerns itself with psychological disorders (Barlow & Durand, 2009).

According to Barlow and Durand (2009) psychiatry is further concerned with the biological treatment of psychological disorders. Whereas according to Sue et al. (2010) psychology entails finding a better understanding of psychological disorders. The overlap between psychiatry and psychology becomes problematic when considering the term phenomenology.

According to Rulf (2003) there are three distinct meanings of phenomenology in psychiatry. He argues that there are first purported by the British and North American psychiatrists who use the term phenomenology as an equivalent to descriptive psychopathology. Therefore the term is used to indicate diagnosis as the focus of psychiatric illness by an unbiased observer. This meaning of phenomenology therefore aligns itself more with descriptive phenomenology.

The second meaning of the term in psychiatry was used by Karl Jaspers by identifying the subjective experience of individuals diagnosed with psychiatric illness. Karl Jaspers did however use the term in a limited sense, looking at empirical procedure in searching for a descriptive psychopathology of the states of consciousness (Rulf, 2003).

The third meaning of phenomenology is used according to Rulf (2003) by continental Europe, North America and countries such as Japan. This understanding of phenomenology is grounded on Husserl, Heidegger and Merleau-Ponty's phenomenological philosophy. It has as its aim describing the essential features of an array of human consciousness and being-in-the world.

Taking into account the theoretical framework of this research project the phenomenology of psychopathology has been understood from different approaches. It has been understood from the descriptive approach by British and North American psychiatrists, description of signs and symptoms by an unbiased observer. It has also been identified

through interpretative means by Europe, North America and Japan; with the aim of expressing qualities of human consciousness of individuals diagnosed with a mental disorder. This research project aligns itself with the second method of understanding psychopathology.

Schizophrenia has gained significant attention with regards to the phenomenology of mental illness. Davidson (in Rulf, 2003) stresses the long standing association particularly of schizophrenia and phenomenology. The link between schizophrenia and phenomenology is strong. This is also evidenced by the large body of publications. .

When identifying the phenomenology of schizophrenia in research the individual's experience becomes pertinent. Formulating meaning in psychopathology allows for a better understanding of the unique experience of individuals.

In their study on the values held by persons with schizophrenia Ballerini and Stanghellini (2007) argue that psychiatry is grounded on the firsthand account of experiences, thus clinical phenomenology should be a central consideration. Because subjective experience is at the core of phenomenology, clinical phenomenology is therefore the "science of abnormal subjectivity" (Ballerini & Stanghellini, 2007, p. 134). From the perspective of clinical phenomenology, research interests should thus be focused on what it is like to be in a certain mental state, and the types of personal meanings that may come from this experience.

Ballerini and Stanghellini (2007) are of the opinion that it is not only at an experiential level that phenomenology and psychopathology come together, they argue that experiences also have another component to them. This component is identified as the subjective quality of an experience. Thus through the proposed research the subjective experiences of individuals' positive symptoms are explored. Ballerini and Stanghellini (2007) argue that through such psychopathological experiences, there comes from it personal meaning and, or values unique to the individual experiencing it. Thus, it is not merely an experience for it generates meaning for the individual.

Adopting a phenomenological standpoint to schizophrenia thus has three implications; firstly it allows for an interpretive frame. Phenomenology acknowledges the inescapability of subjectivity and explicitly uses it in the methodology and method (Corin & Lauzon, 1994).

Secondly a phenomenological perspective increases the range of signs or behaviour to be documented. This means that where psychiatric diagnosis would discard all that is not pathology a phenomenological attitude takes nothing for granted, it is interested in the everyday experience of individuals (Corin & Lauzon, 1994). Thus for the research project at hand all the information participants bring will be taken into account over and above information pertaining to their diagnosis of schizophrenia.

Lastly there is a shift in focus away from the individual as an individual, moving towards a way in which the individual relates to the world "toward the perceived world he lives in and toward the kind of intersubjectivity to which he has a sense of belonging" (Corin & Lauzon, 1994, p.9).

From the aforementioned ideas on phenomenology and schizophrenia it becomes integral to put forth a closing argument on them. There is a relationship between phenomenology and psychopathology. There is a strong indication through published research of a relationship between phenomenology and schizophrenia (Bradfield& Knight, 2008; Kraus, 2012; Maung, 2012; Rulf, 2003). Published research identifies the subjective experience of individuals diagnosed with schizophrenia in a number of different ways. By approaching schizophrenia from a phenomenological framework the interpretive nature of the disorder can be better understood and the lived experience (dasein) detailed.

In relation to the proposed study, the experiences of individuals diagnosed with schizophrenia and the manner in which they relate to and the personal meaning they create in relation to or about the positive symptoms of hallucinations and delusions are explored.

Epistemology and ontology

Epistemology and ontology are concepts commonly presented as fundamental to qualitative research (Carter & Little, 2007). Thus in the consideration of what can be perceived as real and how knowledge can be generated ontology and epistemology are noted. In the following section a brief inquiry into these concepts will be made and their implications for the chosen research extrapolated.

When conducting research the aim becomes to investigate some phenomena. According to Baptiste (2001) that phenomenon under investigation is known as reality. The question dealt with by ontology is what is real (Carter & Little, 2007; Baptiste, 2001).

Difficulties do arise when considering the nature of reality. This, according to Baptiste, (2001) is seen in the facticity and quality of a phenomenon. The facticity of a phenomenon would state that the phenomenon exists in a certain form. Quality on the other hand would thus inform us on the form that the phenomenon exists (Baptiste, 2001).

Ontological positions can be considered on a realist-relativist continuum (Willig, 2008). The realist ontology considers the cause and effect relationships maintained by structures and objects in the world. The relativist ontology on the other hand rejects this view of the world. A relativist ontology according to Willig (2008) questions the “out-there-ness” of the world placing an emphasis on the multiplicity of interpretations that can be applied to it.

Ontological concerns about schizophrenia thus could include; are hallucinations and delusions real? How do we know if these symptoms are real? What does a person diagnosed with schizophrenia’s reality mean?

Ontology concerns itself with the nature of reality and the possibility to better grasp what is true. Due to the phenomenological orientation of the research it subscribes to a relativist ontology. In this regard, although all participants have been given the same

diagnosis, how each individual experiences their disorder becomes open to a diversity of interpretations.

Epistemology differs from ontology in the inquiry into the world. Whereas the question that drives ontology is "what is there to know?", epistemology asks "how can we know?" (Willig, 2008). This research project aims to produce an understanding of Zulu men's understanding of themselves along the backdrop of culture and having being given a diagnosis of schizophrenia.

Epistemology is a branch of philosophy which concerns itself with the theory of knowledge (Carter & Little, 2007; Willig, 2008). Thus epistemology concerns itself with questions on how it is we come to know what we know as well as in what manner we go about gathering knowledge about the world (Baptiste, 2001; Harper, 2012)

There are a number of epistemological frameworks. The three main epistemological frameworks according to Harper (2012) include social constructionism, realism and the chosen framework for this dissertation, phenomenology. Each framework has its own unique characteristics making it unique to other frameworks (Harper, 2012). According to Harper (2012) the key difference amongst frameworks is the extent to which data collected is noted as reflecting and mirroring reality.

Similar to ontology this means that all epistemological approaches can be positioned on a realist-relativist continuum (Harper, 2012). Realism is defined as the degree to which data collected mirrors reality. Certain branches of realism share relativist assumptions of an interpreted reality. On the other end of the continuum radical constructionist believe that everything exists only because we can language about it. Whereas relativism is of the opinion that many valid interpretations exist of the same observation and thus data is not viewed as mirroring reality (Harper, 2012).

Phenomenology subscribes to an epistemology of relativism. Therefore knowledge

that is produced is open for many interpretations. This relativist position is taken in this research as different individuals will be commenting on their individual experience of their hallucinations and delusions.

Conclusion

In considering the phenomena to be discussed a theoretical framework becomes important as it underpins the method and methodology to be considered. Epistemology is related to the manner in which one acquires knowledge and understands the world (Harper, 2012). Thus for the proposed research the epistemological framework chosen is that of phenomenology.

Phenomenology has at its core the subjective experience of individuals. Within phenomenology a number of different approaches exist of which there are two major proponents. From these an interpretive, hermeneutic stance is taken as it allows for an interpretation of each person's experience. In relation to the population of the research, interpretive phenomenology considers an individual's experience as all encompassing. Such that one's cultural and social contexts become important in the appreciation of the individual's experience.

Thus for the men diagnosed with schizophrenia their individual experience of hallucinations and delusions becomes important. Furthermore their culture as Zulu men and the society that they are a part of become an important consideration in their individual experience.

Chapter 4: Method and Methodology

Introduction

In this chapter the methodology and method employed in the research will be discussed. Although the two terms are often used interchangeably they refer to different aspects of the research process (Willig, 2009). Methodology refers to the general approach taken to study topics of research whereas method refers to a specific technique of research (Willig, 2009). Therefore the general approach used in this research will be discussed in this chapter. Specific attention will also be given to participant selection, data collection and analysis.

In all forms of research it becomes integral to consider the manner in which the quality of research can be improved. In this chapter this is also considered, with a detailed description of reflexivity, as well as ethical issues.

Because the research population are people diagnosed with schizophrenia numerous ethical aspects needed consideration. Ethical issues need to be detailed as this population is already considered an at-risk population. Relevant ethical considerations will also be regarded in this chapter.

Qualitative research

Qualitative research is concerned with the formation of meaning. Thus researchers become interested in the manner people make sense of their world and the manner in which they experience events (Willig, 2009).

Qualitative research is described by Nieuwenhuis (2007) as research rich in data with regards to particular phenomena. The intention being to gain a greater understanding of what is observed and studied (Nieuwenhuis, 2007; Willig, 2009).

According to Nieuwenhuis & Smit (2012) qualitative research requires an understanding of the processes that facilitate behaviour patterns. In this regard culture and social context become important elements in the understanding of a person's experience.

Furthermore qualitative research is not a unified approach as there are different approaches. Different types of approaches include ethnography, grounded theory, action research and narrative inquiry (Niewenhuis & Smit, 2012; Willig, 2009).

The qualitative approach to be employed is dependent on the nature of the inquiry at hand. Grounded theory aims at providing explanatory theories which benefit at understanding the phenomena at hand (Willig, 2009) This method was not chosen as the method for this research project as the aim was not on theory formation or providing an explanatory framework from which to better understand Zulu men diagnosed with schizophrenia. Similarly ethnography was not chosen for this project as the aim was not to study the lives of participants in their natural settings in order to better understand cultural nuances (Niewenhuis, 2007).

As this research project is concerned with the participants' individual experience of their hallucinations and delusions, IPA will be utilised both as research method and methodology.

Methodology

The methodology employed during this research was IPA. It has as its main aim the exploration and further detailed understanding of an individual's personal and social world (Osborn & Smith, 2008). This method is phenomenological in that there is detailed description of the individual's life world. There is an attempt made to explore personal experience and it is concerned with an individual's subjective perception or recollection of an event or object (Osborn & Smith, 2008). Similarly, Larkin and Thompson (2012) state IPA's phenomenological grounding insofar as the interpretation of accounts and events. They

further elaborate that outcomes of an IPA study include giving a voice to the experience of research participants, in addition to making sense of material through interpretation.

IPA proceeds on a number of assumptions. The first assumption states that in order for one to understand the world it is required that one must understand experience; secondly in conducting research using IPA, researchers engage with the personal accounts of participants who are at all times engaged in the world, whether it is linguistically, culturally, cognitively or affectively (Eatough & Smith, 2007 & Larkin & Thompson, 2012). Therefore an ideographic approach needs to be taken in order to focus on detail.

Other assumptions include the need for researchers to identify and reflect on their own experience and assumptions in order to engage with other people's experience and lastly that interpretation cannot be escaped from at any stage (Larkin & Thompson, 2012). What researchers can do however is to reflect on their role in the production of interpretations as well as maintaining a commitment to ground these interpretations in the views of participants.

Method

IPA as research method. Interpretative phenomenological analysis aims at collecting rich data and uses a specific method of analysis in order to guide the interpretation of people's accounts of experiences.

Interviews as gathering technique. The predominant method for data collection in IPA is a semi-structured interview (Langdridge, 2007). Semi- structured interviewing was utilised as a data collecting technique. It allows room for the researcher to hear the participant talk about a particular aspect of their life or experience (Willig, 2009). In this regard a great deal of meaning can be conveyed from individuals' experiences. Furthermore the semi-structured interview focuses on the interview in that it aims to answer the research question. It also serves as a compass because it aims to keep the conversation in line with the objectives, and thus the aim of the study.

Interview schedules are constructed with relatively open-ended questions, on the topic under investigation. Questions to consider in the interview schedule include asking participants to reflect on the different aspects of the experience. From the reflective questions a holistic understanding of the participant will emerge taking into account their cultural and social context (Langdridge, 2007).

Emphasis is placed on meaning in semi- structured interviewing, compared to lexical comparability (Willig, 2009); the researcher focuses on what is meant by interviewee regardless of the manner in which it is conveyed. Thus experiences of and meanings derived about hallucinations and delusions of participants were identified with an attempt to understand meaning held for the participants. This allowed room for participants to further elaborate on questions posed to them when warranted.

In constructing the semi-structured interview for this research, certain questions were considered in line with the aims of the research. These included questions about culture, the identification of one's self within the culture as well as ideas around obtaining a diagnosis of schizophrenia. Questions were also posited in line with the literature review. This became meaningful in the consideration of past research on the unique experience of experiencing positive symptoms. In positing such questions a holistic understanding of the participants experience and the manner in which they make meaning was possible. In this regard semi-structured interviewing as data collection appears most beneficial for IPA as it allows for the articulation of detail of the experience. See Appendix C for the semi structured interview in English.

Participant selection. Sampling refers to the process used to select a section of the population for the study (Nieuwenhuis, 2007). As the research is qualitative in nature sampling methods are based on non-probability sampling and purposive sampling. Purposive sampling was utilised, in that the members of the population were selected on the grounds of

predetermined characteristics (Nieuwenhuis, 2007).

Interpretative phenomenological studies require a fairly homogenous group (Osborn & Smith, 2008). And therefore purposive sampling was utilised. This ensured the researcher was able to speak about a certain group of people and to be idiographic. Thus participants were chosen with specific characteristics based on predetermined exclusion and inclusion criteria.

Inclusion criteria. The inclusion criteria for participants were gender, in that they are male and ethnically they are Zulu speaking. As the researcher is Zulu and speaks Zulu as a first language this made the population accessible to her. Furthermore coming from a Zulu background herself, the researcher is able to identify and understand cultural nuances, which aids in personal and epistemological reflexivity.

Additional inclusion criteria entailed diagnosis. Thus participants chosen have been given a primary diagnosis of schizophrenia current episode, exhibiting positive symptoms as diagnosed by a multi disciplinary team at Weskoppies Psychiatric hospital. Furthermore the participants are between certain ages, namely 18 and 35 years of age. Having spoken to the Head of Psychology at Weskoppies hospital he explained to the researcher the different types of populations available for persons diagnosed with schizophrenia.

Weskoppies Psychiatric hospital has a number of units catering to different diagnoses given to individuals. Adults who have been diagnosed with a disorder where they exhibit psychotic symptoms, whether positive, negative or disorganised are placed in one of two units. These units range in age of individuals. The first of these firms, the complex young psychotic disorders unit caters to males and females between the ages of 18 and 35 years old. The second unit is the complex mature psychotic disorders unit which caters to males and females of 35 years and older.

The population between 18 and 35 years was chosen as there is more likely to be

more individuals in that population at the hospital. Thus for sampling purposes the researcher is more likely to get a greater sample from this population at the hospital.

Exclusion criteria. Exclusion criteria included the following; participants who had been compromised by their illness to the degree that they could not give consent to the research. Secondly persons diagnosed with substance-induced psychosis were excluded. These individuals were also included as the symptoms experienced when given this diagnosis generally are present with the use of substances and tend to dissipate once substance use has come to an end. Provision was made for potential participants to be included in the study who had used cannabis.

Having spoken to the Head of Psychology at Weskoppies hospital he explained the difficulty in excluding individuals who had abused cannabis. This he explained is due to the fact that the majority of persons who have been diagnosed with schizophrenia and are currently at Weskoppies hospital have at one time or another in their lives abused cannabis. Thus it would have become very difficult for the researcher to find participants for the study if one had to exclude individuals who had abused cannabis.

Thus the provisions made for persons who had abused cannabis at some point in their lives were as follows. Potential individuals were considered if they had been clean from cannabis for a period of six weeks. Secondly participants who had used cannabis were considered if the multi disciplinary team was of the opinion that the cannabis did not play a role in the Axis-I diagnosis.

Finding participants who matched the inclusion and exclusion criteria of the research became quite a challenge. The greatest difficulty in the inclusion and exclusion of the participants was that of the ethnicity. Although a large sample was made available to the researcher of men who had been given a primary diagnosis of schizophrenia, finding participants of Zulu ethnicity became a challenge. Potential participants who had been

screened were able to speak and understand Zulu but were Siswathi, Ndebele or Xhosa. Culturally they did not identify themselves as Zulu men. This resulted in a greatly reduced sample size expected. See Appendix A for the invitation to participate in the research.

Sample size. According to Osborn and Smith (2008) IPA studies are conducted on small sample sizes. The small size allows for a more detailed analysis of each case chosen rather than making general claims of a larger population. Thus IPA studies take on an ideographic approach (Osborn & Smith, 2008; Willig 2009) in that insights produced result from the rigorous analysis of a small number of cases.

According to IPA there is no right answer to the amount of participants chosen for research (Osborn & Smith, 2008). Deciding on the sample size depends on several factors namely; "the degree of commitment to the case study level of analysis and reporting, the richness of the individual cases, and the constraints one is operating under" (Osborn & Smith, 2008, p. 56).

Before the commencement of the research, I considered using a sample of five participants. However a number of unanticipated challenges resulted in the sample size being three participants. The difficulty in finding five participants fulfilling both inclusion and exclusion criteria were such that only three such participants were a part of the research. Initially five Zulu speaking men were screened to be a part of the research. From these five men only three of them identified themselves as being Zulu. The other men were Xhosa Ndebele and Siswathi. These three participants ranged in age from 19 years old to 38 years age. In re-reading transcripts of three participants interviewed only two of the participants' interviews could be used. The rationale for not using the third participants' transcript for the research is detailed in the last chapter of the dissertation under epistemological reflexivity.

Data analysis. Qualitative data analysis methods differ, but are generally based on an interpretive philosophy, such that an emphasis is placed on the experiences, attitudes and

perceptions of a particular phenomenon, (Nieuwenhuis, 2007).

IPA has its own method of data analysis, which aims at capturing the "quality and texture of individual experience" (Willig, 2009, p. 57). Osborn and Smith (2008) note the use of audio recorders and transcription during an IPA study. They are of the opinion that without audio recording only the gist of an experience will be captured therefore important nuances would be missed. In this study I used an audio recorder to record all interviews conducted. After which I would transcribe the interview, taking into account pauses, hesitation and other nuances from the interview.

IPA transcription is at the semantic level (Osborn & Smith, 2008) in so much that one needs to consider all the words spoken. This semantic level includes the consideration of "false starts; significant pauses, laughs" (Osborn & Smith, 2008, p. 65).

There are various stages included in the analysis of an IPA study (Langdridge, 2007; Osborn & Smith, 2008; Storey, 2007; Willig, 2009). The first stage of analysis included the reading and the re-reading of transcripts. The left-hand margin was used to annotate any interesting or significant responses by participants (Osborn & Smith, 2008). At this stage I read each transcript individually taking into account significant responses in the interview and marked these down.

At the second stage of analysis themes were identified and labelled (Storey, 2007). Thus at this stage the left hand margin notes that I had previously marked down were then translated into themes. In conceptualising themes I considered the need to capture something about the essential quality of what was represented by the transcripts.

The third stage of analysis included the connecting of themes (Osborn & Smith, 2008). In this regard I tried to make connections in the themes that were emerging. It was at this stage that I noted that some themes being more prominent whereas some others became subordinate themes.

At the fourth stage I produced a table of superordinate themes (Osborn & Smith, 2008). This summary table included those themes that captured the quality of the phenomena under investigation (Willig, 2009).

Measures to enhance qualitative research. In conducting qualitative research it is important to keep in mind what constitutes good quality research. Willig (2009) notes various factors to be kept in mind in formulating good quality research including; the importance of fit, integration of theory, documentation, sensitivity to negotiated realities, reflexivity and transferability. Guba refers to four criteria that allow for reliable research including; credibility, transferability, dependability and confirmability (Shenton, 2004) Detailed discussions on these measures used to enhance this research as proposed by Guba are noted in chapter six. Brief overviews of the criteria that enable qualitative research to be deemed trustworthy are stated below.

Importance of fit pertains to the categories generated by researchers fitting with the data cohesively (Willig, 2009). Thus researchers need to write comprehensively and clearly on the reasons why phenomena was categorised in that manner (Shenton, 2004).

This was done in this research study in choosing a methodology and method that would complement the aims and objectives of the study. In the integration of theory, the relationship between different themes needs to be clearly understood in addition to "their integration at different levels of generality should be readily apparent" (Willig, 2009, p. 150).

The integration of theory was considered in this research through relating themes that became apparent to the research methodology and method employed. In documentation, the researcher needs to provide a comprehensive account of what was done, and the reasons thereof throughout the research process (Holland & Kawulich, 2012). In this chapter there has been a detailed discussion on the research process. Such documentation includes the research method and methodology used IPA, and the reasons thereof. Furthermore

documentation detailed participant selection, sample size and method of analysis.

Reflexivity is important because it influences the manner in which the researcher engages with the proposed investigation. It thus takes place on two levels; personally and epistemologically. Personal reflexivity occurs as the research influences and shapes the process as person, whereas epistemological reflexivity occurs as the research is influenced and shaped by theory (Shenton, 2004).

In qualitative research it is thus important to consider reflexivity as it allows the researcher to reflect on their experience of conducting research. It also creates room for the researcher to consider and reflect on the manner in which certain insights and understanding have been reached (Willig, 2009). Epistemological reflexivity thus allows us to reflect on assumptions that have been made in the course of the research, helping us to consider the implications for the research and the findings thereof (Shenton, 2004). A detailed discussion on reflexivity is noted in chapter six.

Ethical considerations. Much has been written on the ethical concerns of undertaking research with persons diagnosed with schizophrenia (Anderson & Mukherjee, 2007; Stanley & Wilson, 2006). These authors are of the opinion that persons diagnosed with schizophrenia are an already vulnerable population, thus any research to be conducted needs to take care to not place these individuals at unreasonable risk.

Important ethical considerations that were taken into account when conducting this research included ideas around informed consent, the capacity to consent, potential sensitive material shared and confidentiality.

In conducting research with a population of persons diagnosed with schizophrenia, Anderson and Mukherjee (2007) are of the opinion that this brings with its own set of unique challenges. Prominent to these challenges is the process of obtaining informed consent. Informed consent is defined as a “voluntary choice by an informed and capable individual to

participate in research" (Anderson & Mukherjee, 2007, p. 647).

These authors note that obtaining informed consent from persons diagnosed with schizophrenia becomes challenging due to the symptoms of the disorder. Positive symptoms, behavioural patterns and noted flattened affect may pose a challenge throughout the research process. Furthermore Anderson and Mukherjee (2007) note that symptoms may fluctuate over time which may result in a shift from periods of being able to consent and periods of psychosis and incapacity.

Tying in with challenges of obtaining informed consent and the capacity to consent, Krüger and Van Staden (2003) are of the opinion that in cases of mental illness the capacity to give consent can be better informed. Thus considerations are made on conditions necessary to give informed consent rather than broad inferences made from general features of a specific diagnosis (Krüger & Van Staden, 2003).

There are two types of conditions that need to be considered in the obtaining of informed consent. Standard conditions of obtaining informed consent refer to those conditions of information sharing, a lack of coercion into participating in the study as well as trust (Anderson & Mukherjee, 2007; Krüger & Van Staden, 2003). The second set of conditions according to Krüger and Van Staden (2003) are those that cannot be met owing to a mental disorder. Thus they are of the opinion that although these conditions are not necessarily sufficient each one is necessary.

There are four criteria that need to be considered in the capacity to give informed consent and they are that: (i) the mental disorder does not prevent a patient from understanding what they consent to, (ii) the mental disorder does not prevent the patient from choosing for themselves whether they are for or against intervention or participation, (iii) the mental disorder should not prevent patient from communicating their consent and lastly (iv) the mental disorder should not dissuade patient from accepting the need for medical

intervention or participation in research (Krüger & Van Staden, 2003).

For this research a clinical assessment was conducted before the informed consent form was given. This was done in order to determine whether participants chosen for the study met the four criteria for informed consent as noted by Krüger and Van Staden (2003).

At the time of the clinical assessment a level of information sharing was necessary between the treating psychologist and the potential participant. Information sharing at this period centred on explaining the purpose of the screening and its use for the research purposes. It was only after this evaluation that the psychologist informed the researcher of the suitably of participants.

When participants were considered suitable for the research then only did the researcher meet with participants, in order to sign the informed consent. As information sharing is an integral part to informed consent, it was at this time that the researcher disclosed information on the research including, the aims of the study, potential risks and benefits of participation as well as alternatives to participation (Anderson & Mukherjee, 2007). See Appendix B for the informed consent form.

Due to the symptoms of schizophrenia, Anderson & Mukherjee (2007) are of the opinion that persons diagnosed with schizophrenia however may not fully grasp the process of information sharing while informed consent is being explained. According to them symptoms of schizophrenia may compromise this process.

One way of evading this challenge is the oral reading of information by the researcher as well as providing the opportunity for participants to ask questions (Anderson & Mukherjee, 2007). In using this technique Anderson and Mukherjee (2007) are of the opinion that persons diagnosed with schizophrenia demonstrate a level of understanding of informed consent. Thus, during this period information was clarified with the potential participants both orally and in writing. This allowed for further queries by research participants. All but

one participant readily consented. This participant wanted more information on the research study. Clarifying the study with the participants led to him consenting to be a part of the research.

Chambers and Thompson (2012) are of the opinion that researchers need to reflect on what way the specific context of their proposed research study can create vulnerability. With regards to this research potential vulnerability could occur during the interview process.

While conducting interviews themes may occur that are of a sensitive nature to the participants (Chambers & Thompson, 2012). To safeguard this potential vulnerability the researcher liaised with the participants' attending psychologists before and after interviews.

The researcher needs to be equally aware of their own vulnerabilities while engaging in a research project (Chambers & Thompson, 2012). In this regard supervision is necessary in order to help researchers explore their emotional reactions and explore the impact this may have in conducting the research (Chambers & Thompson, 2011).

Thus throughout the research process the researcher was in research supervision exploring her emotional reactions to what had been shared by participants. As well as exploring the impact these reactions may have in conducting the research.

Precautionary steps need to be taken in limiting access to confidential information. In the instance of psychiatric research, Avasthi, Ghosh, Grover and Sarkar (2013) are of the opinion that researchers need to be aware of the possible ethical challenges surrounding confidentiality. The most effective strategy is thus to remove any information that may identify research participants from medical records before any research use (Avasthi et al., 2013).

In removing identifying information researchers avoid the possible discrimination or stigmatisation of their participants (Avasthi et al. 2013). Which these authors state may be a possible effect of having participated in the research. Thus for this research steps were taken

to limit access to confidential information. Therefore participants names and surnames were not used in the study to protect their identity. Furthermore no information was detailed that would make tem identifiable including the wards that they were in at the time of admission at Weskoppies psychiatric hospital and the names and surnames of family members.

Conclusion

This chapter focused on the method and methodology used for the research study. Qualitative research was used for this research as it is concerned with the formation of meaning. Thus the formation of meaning for Zulu male participants diagnosed with schizophrenia can be explored. Within qualitative research the approach to be best suit aims and objectives of the study was IPA.

This qualitative approach was chosen as both method and methodology of the research study. The core motive of choosing IPA as methodology for this research study is that it has as its main aim the exploration and deepening understanding of an individual's personal and social world. Thus participants diagnosed with schizophrenia used for the research study's personal and social worlds could be explored with a great deal of understanding.

The method used for this study was also IPA. As method, IPA has at its aim collecting rich data using specific methods of analysis. The method of IPA also includes detailing interviews as gathering technique, participant selection, data analysis and the ways to improve quality research. Due to persons diagnosed with schizophrenia being considered an already at risk population a detail discussion of ethical considerations was accounted for.

Chapter 5: Findings

Introduction

This chapter aims to elaborate on the lived experience of two men diagnosed with schizophrenia. The interpretative phenomenological framework used to understand the two participants was concerned with their lived experiences including; the lived experience of being a Zulu man as well as their experiences of mental illness against the background of their culture.

Following the IPA method, descriptions of each interview conducted were analysed. Subsequently interviews were grouped into themes and subordinate themes pertaining to each of the participants' experiences of their hallucinations and delusions.

The following section will look at the analysis of each participant with themes and subordinate themes. In keeping with confidentiality the names of all participants have been changed.

Mzwandile

Mzwandile was the first participant interviewed for the research. He is a 38 year old male from Mpumalanga who is not married and does not have any children. A ward conference was conducted on him at the hospital where he was given the diagnosis of schizophrenia with positive symptoms of grandiose delusions by the multi disciplinary team. He believes that he is the President of South Africa and that he has the ability to influence important proceedings. These proceedings include high profile court cases in the media. He also believes that when he feels certain emotions other people will feel them too. Thus when he experiences overwhelming sadness, others around him will feel these emotions too.

On first meeting him he was apprehensive. He was unsure whether meeting me would prolong his stay in the hospital which he felt was unwarranted. However the more

comfortable he became the more he was able to speak about his experience and became quite meticulous in his need to clarify certain things.

Prominent themes and sub themes in *Mzwandile's* transcript included; the experience of being a Zulu man in what he perceives as a dominant authoritarian culture, the experience of family relationships, his education and subsequent occupational history as well his experience of mental illness.

Education and occupation opportunities. In order to obtain rapport with *Mzwandile* and to put him at ease at the beginning of the interview questions that were seen as relatively unthreatening were started with. Some of the background information obtained included speaking of his schooling and occupational history.

Difficulty in academics. He mentioned that he left school in grade 4 because he struggled. When asked about whether he had finished school he first appeared hesitant and was unwilling to speak about his schooling.

I stopped at standard, standard 2 ... That's a long story I changed.

Mzwandile appeared to have experienced schooling as a challenge. It appears that he left school due to this repeated failing.

Criminal activities as a means of financial stability. Having left school it appears that he turned to crime, stealing cars. Having struggled with school and dropping out he experienced a shift in him with the need to turn to crime. It almost seems that because he struggled academically and left school there was no other path for him to take but to start stealing cars.

... And got into stealing. I was stealing cars ... when I was about 20 or so. I was failing, failing a lot.

Dissatisfaction in financial remuneration. Difficulties he had in obtaining a formal education had led to him finding other means to gain an income or become employed. There is the experience of needing to obtain money and provide for himself. Thus he turned to crime for survival. The period in his twenties where he moved to Pretoria to gain employment appears to be marked by frustration.

> *I worked when I was still staying in Pretoria. I was quite young ... I was a labourer. Yes I was working with cement and plastering you see things like that. I was also working in the gardens. But at the time I was only getting paid R10. Long ago.*

Although he had left a life of crime and started working as a labourer the money he was getting he felt was very little. In growing up to be a Zulu man it seems that *Mzwandile* had great difficulty in schooling which led to a path of crime. This was further challenging when he was older and began to work as the money he was getting from employment was little.

The experience of family relationships. *Mzwandile* spoke at great length about his family and where he comes from. One of the first things he mentioned about his family was that prior to admission to the hospital he was living at his grandmother's house along with his brother and his children.

The experience of rejection from family. He currently experiences his family as rejecting of him. It appeared that at home his behaviour had becoming troublesome and his family were unable to handle his behaviour. It seems that he feels quite rejected by his family as they do not want him to come back and stay with them.

> *Where I was staying is at my grandmothers. At my grandmother's they say they don't want me anymore.*

The experience of a displaced family. Mzwandile's family is spread out across the area where they reside. His family comes across as very disjointed as different family members live in different areas and his sister and father are deceased.

> *So where my actual family is from is at Mhlanga there. There is my father you see? Now my father is dead. Now I don't know whether my father's wife is alive. I don't know' if she is alive because I haven't seen them in a long time. The children that are there* (grandmother's house) *are my brothers. My sister she died.*

He experiences his family as being quite distant from each other, having grown up in one area he had later moved to another area. A hierarchy exists in his family with regards to his mother, and his father's first wife.

> *You see now my mother, my mother is the second wife. Then there is the first wife but she stays in a different place. Now my father he was staying at his own place I was raised with my mother.*

Thus they appear to function as three separate households. His father as the head of the household lives in a different location from both his wives. Furthermore he was apart from his father as he was raised by his mother. He appeared to have had a more emotional bond with his mother as he was raised by her and had physically resided with her while he was growing up.

The experience of being a Zulu man. When speaking about the experiences of being a Zulu man there was a lot of emotion evoked in him. There is a lot of pride for him in his surname which for him indicates that he is Zulu. He also mentioned that although there is a small population of Zulu people where he is, Zulu people are present in the community. His family however he states are originally from the area.

Most of the time people come from the rural areas...In Natal and they come this side to Ndebele. My family is from right here (Ndebele)

Zulu men as authoritative and stern. In describing Zulu people he mentions that they are very stern. He experiences Zulu people as authoritarian and powerful. He further experiences Zulu people as showing their dominance through physical force. He also experiences Zulu people as people to be revered, to be feared. Furthermore there is justice and rules within the culture. These rules for *Mzwandile* are abided by everyone in the culture and enforced by men.

Maybe I can say that they are people who like to hit others... they hit alot their sticks. What I mean is their rules..they are people with the truth..The things they do have truth and they do it like they are told..it is a person who is feared.

Mzwandile demonstrates the powerful nature of Zulu men. He states that if matters are not handled in the appropriate manner these will not be conducted. Thus Zulu men have the power and authority to prevent affairs if done in the incorrect manner.

... Yes things are done in certain manner and things will be prevented from being done if they are done incorrectly

Zulu men as apathetic. In light of being a Zulu man he sees this question in a different light from that above. Although he experiences Zulu men as people to be feared and dominant, he also experiences Zulu people as respectful people. A third manner in which he experience Zulu people is that of being lazy.

They are people who don't like work ... the work they do they don't like, they like to sleep. They maybe generally like to be at the taxi ranks so that work.

Self as Zulu man. His identity and how he experiences himself as a Zulu man seems different from the manner in which he experiences the Zulu culture. When speaking of himself there is a lot of shame and embarrassment which he says is due to his past failings. There is an awareness of these past failings which he states do not live up to what it is to be a Zulu man. Thus there is the experience of not living up to the standards of the culture. He experiences himself as a quiet, isolated and reserved which opposes his earlier ideas that Zulu men are brash and authoritative and feared. These opposing views attribute to the positive and negative features he sees among Zulu men.

> *Well me..I am a person who has my bad things but I like to be on my own. You are the only person who knows your business all alone you see? So you are strong. And you mind your business and work hard and you can see you are strong. Yes I work with my whole heart.*

In his understanding of the Zulu culture he speaks of the authoritarian nature of it. These rules of the Zulu are set and they are not swayed. He describes the culture as being very restrictive if one had to move out of line of what they are supposed to do.

> *The Zulu culture like I told you previously they live by the stick. The rules of the Zulu is the stick and it is only about the stick. Yes things are done in a certain manner and things will be prevented from being done if they are done incorrectly.*

The experience of mental illness. As mentioned previously *Mzwandile* has delusion of grandeur. He currently denies having a psychiatric illness. He experiences everyone as fearing him and being envious of him and that is why he is currently in hospital. He believes that he can influence high court proceedings. This is similar to his feelings on Zulu men being feared and revered by others.

He also believes he can influence high court proceedings. He experiences great pride

at being able to influence proceedings in this manner. Similarly the ability to influence court proceedings for *Mzwandile* relates to the justice and truth that Zulu people have, and how justice is enforced by Zulu men.

Feelings of resentment. He is however resentful of everyone including hospital staff from keeping him from influences these proceedings by keeping him in the hospital. According to *Mzwandile* he has a lot of power and he is feared by everyone. Being powerful is one of the positive attributes attributed by *Mzwandile* of being a Zulu man. And along with the power come people who fear Zulu men. His name becomes important to him when describing how powerful he is.

> *You see me, you see the way I am my name. I am the one who sets the affairs on the outside. On the radio when they speak of the President at the court or in jail they speak of me but I am on the outside.*

Feelings of overwhelming emotion. In experiencing himself as a powerful man he describes his ability to control phones and others being fearful of him for being able to do this. He experiences overwhelming emotions which he then feels that everyone can feel. This overwhelming emotion that he describes that others then feel is similar to a delusion of reference. Thus he is of the opinion that his feelings and emotions will influence those around him.

> *I was at new lock ... I was talking with my stomach and I didn't eat for a whole two weeks ... I had a cellphone and on top of that when the cellphone rings and someone picks up they can hear me and I am crying like a child. Maybe you throw away your phone away when this happens because you think the phone is haunted but it was just me. So when they speak of the President at the court they speak of me.*

I was feeling that the world was going to end the world was going to end. It was going to end and then there again there will be young white people young Zulu people, young Ndebele people and young China people so the whole world can be open again you know? Not like now you see? Right now it's all closed. In the world people are suffering everything is closed you see?

Denial of mental illness. For him he is currently not ill and he complies with taking medication but he is certain that this is not helpful to him. In this manner the hospital and the medication he takes become the dominant authoritative Zulu man whose rules he has to abide by. He follows these rules although he doesn't believe it is helpful. This is similar to the positive and negative attributes of being Zulu describing at times where he is unlike Zulu men. Thus he takes the medication, although he doesn't see the benefit. He is almost defiant in describing this.

Furthermore *Mzwandile* is of the opinion that nobody believes him. And that he is given medication because he is lying. Thus he experiences everyone having little to no belief at what he has accomplished before he was sent to the hospital.

They say I am ill in the head ... they mean that the way I am, I am ill in my head but I think they are just scared of the work that I have done on the outside.

I arrest people who have done robberies or some people who steal cars. I feel that they maybe think actually that the work I did outside is not real. Now it's better I drink medication...they say I am sick.

Zulu culture and mental illness. As he mentions he does not feel that he has a mental illness. As a Zulu man he further states that there is no such thing as a mental illness and does not experience this as having a cultural dimension whatsoever.

No. In Zulu there is no such thing of having a sickness of the head..no there isn't.

For *Mzwandile* there is a lot of pride with being associated with the Zulu culture. He sees Zulu men as strong, assertive and respectful. Equally he experiences being a Zulu man as being revered due to the physical force that they exert but also that they are feared. Although he associates these characteristics with himself he also views himself as someone separate from the typical Zulu man by his definition. Thus he is more reserved, and is a hard worker which is contra to what he says Zulu people can be.

With regards to mental illness he does not experience himself as a person with mental illness. He currently experiences pride for the proceedings he feels he is able to affect and his current status as the President of South Africa. He rather feels that everyone is envious of him as he is important, and that by keeping in the hospital he is being restricted in the greatness that he can achieve.

Mandla

Mandla was the second and the younger of the two participants interviewed for the research. He is an 18 year old male from Johannesburg who currently resides at home with his older brother and parents. He is currently in Matric at a bilingual high school. He has had several admissions to Weskoppies hospital over a short period of time. Following a ward conference for *Mandla* the multi disciplinary team diagnosed him with schizophrenia; exhibiting positive symptoms of auditory and visual hallucinations.

Throughout the interview *Mandla* came across as confident and at times over confident. Rapport was easily established with him and he openly voiced on occasion his annoyance and frustration when asked about mental illness and whether he believed he had a mental illness.

Following the analysis of *Mandla's* transcript the following themes appeared; the

experience of culture and the formation of identity, the relational experience of being a member of his family as well as his experience of mental illness. See Appendix D for the translated transcupt of Mandla's interview.

The experience of culture. In his experience of culture and more notably Zulu culture, *Mandla* spoke about his experience of Zulu people as well as his identity in the Zulu culture.

Zulu as a culture of respect. *Mandla* sees the culture and its people of being respectful. There is the experience of solidarity among individuals and the respect of elders. This respect of elders appears to be a genuine respect for people older than him regardless of ethnicity.

> *Zulu it's a special agreement of doing things in a manner that is respected ... we are not disrespectful of people, and we know our adults.*

Self as Zulu man. *Mandla* also speaks of his experience of the relational dynamics of being a Zulu male. For him to be a Zulu man also comes with being the authority in the household. Thus there is the experience of being the authority at home and of being dominant over women. To be a Zulu man for him comes with a level of assertiveness. Thus he subscribes to physical punishment of a woman by her husband as culturally appropriate. This however contradicts his earlier ideas on being respectful. On physical punishment of women by their partners there is a melodramatic quality to the manner in which he describes it. It's as if physical punishment at this level goes beyond being culturally appropriate.

> *We know how to control our women we fuck them up (laughs) ... Well when they come late at home then they know what must happen. Like if my mom comes home at a time that my dad said she mustn't come she will get slaps. You understand?* (Would you do the same thing with your woman?) *Ya.*

In elaborating on his own identity within the culture, he experiences pride in being a Zulu man. When asked how he would describe Zulu men he responded:

Man the best men in the world!

Along with the pride that he feels, the Zulu culture for *Mandla* is where he feels the most where he belongs. There is a camaraderie that he experiences as being a part of Zulu culture that is predominantly forged on language. During the interviewing he revealed that he was not actually Zulu but Swathi, but that he considered himself to be a Zulu man due to the language he speaks. Thus there is the experience of a bond felt with others which leads to feelings of belonging.

I am Swathi but a Zulu man. Ya I can speak Zulu but not Swathi..I see myself as Zulu because I speak Zulu.

Mandla has a broad understanding of how he has formed his identity. He experiences culture for himself as predominantly Zulu, through language. However the experience of being raised and brought up with people of different races and cultures leaves him with the experience of a fluid cultural identity.

At 8 (years old) *we moved to Kempton Park and then I started becoming friends with everybody and then ya..I mostly have white friends*

Schizophrenia and Zulu men. On mental illness and culture *Mandla* He firstly notes that the Zulu culture would be able to describe what it is to have schizophrenia. However *Mandla* is of the opinion that Zulu culture would see this as only being due to the use of substances.

He (a Zulu man) *would say you are sick in your mind. Ya from drugs or dagga*

He firstly notes that the Zulu culture sees mental illness as an illness. He experiences the culture as being able to recognise and take on the idea of being ill.

(How do you think he would see mental illness as a Zulu person?) *He would say you are sick?* (So it's almost like you guys see it as a sickness?) *Ya.*. (And do you think Zulu men are able to see that sickness) *Ya.*

Mandla later changes his statement stating that the following ideas if illness may not be so. He says that culture may deny the existence of the illness altogether. He experiences the Zulu culture as not deeming mental illness as something that is in existence.

It depends on how you handle it. Like a Zulu man (pause) he might..he might disagree with that.

The relational experience of being a member of his family. The second theme that was noted in *Mandlas's* transcript was the relationship between himself and his family.

Strained family relationship. *Mandla* currently experiences a strained relationship with family which appears to be affected by a diagnosis he experiences as unfounded.

My mom said my head is not fine..ya so I went there (Tembisa hospital) *they sent me for a check up and I stayed there for many days ... about 18 days and then I moved to here* (Weskoppies Hospital).

Mandla appears to experience annoyance at his family for their current ideas on their functioning. The majority of this frustration during the interview appeared to be directed to his mother who had noted his bizarre behaviour.

I don't know. She's like, she thinks I am sick. By like, I am damaged in my head, I don't know how to explain it ... She says I laugh on my own, stuff like that so.

Disregard of family's opinions. His family has strong ideas about him being ill and it appears that they have voiced these to him directly. He becomes quite dismissive of his parents' ideas when they confront him with the bizarre behaviour they had seen. *Mandla* appears to be able to explain away for himself some of the reasons why he had been behaving bizarrely according to his parents. When his mother had confronted him about him laughing and talking when alone, *Mandla* explained this away by stating:

> *Ya I was thinking about my friends like you know the times we had together (pause) so like everything and braai's and stuff like that (pause) ... I was thinking about them and times like that so then ya.*
>
> *Ya sometimes I laugh in the car for jokes, and then she thinks I am crazy.*

Experience of alternate forms of healing. *Mandla's entire family as noted above* had voiced their concern as they felt that he was ill. His family had taken him to a place of prayer in the hopes that this would help with his illness. *Mandla* seemed to have undecided feelings about this experience at Morea.

> *They took me to Morea last year so that I can get help there. I wasn't sick they just took me ... It was fun it wasn't bad.* (Asked Mandla why would one go to Morea) ... *It's for healing* (Did you find healing?) *Umm I wasn't sick so I didn't find any it wasn't fun I wanted to go home.*

Experience of mental illness. When *Mandla* was asked about why he had been admitted to the hospital and the diagnosis he had been given he became overtly agitated and frustrated at questioning.

Denial of mental illness. He experiences frustration at everyone around him as he is of the opinion that he does not have an illness. Although he can verbalise his diagnosis there

is a denial in understanding his current diagnosis. He experiences the idea of having a mental illness as being detached from him.

> *I am not really sick so I am here for nothing ... they do* (give him a diagnosis) *but it doesn't make sense cause I went for a CT scan and the CT scan must say what's wrong.*

When asked about his schizophrenia diagnosis in particular he once more experienced agitation as he does not see himself as being ill.

> (What was the diagnosis they gave you?) *Schizophrenia ... mental sick and I am not even I don't even use drugs ... Ya it doesn't make sense.*

Desire to prove mental stability. *Mandla* then began to give symptoms he perceived were those of schizophrenia, in an attempt to show that he does not have the illness. Although showing poor insight about his diagnosis he appears to experience desperation in his effort to prove that he does not have a mental illness. This desperation came in the form of listing numerous symptoms that he felt didn't apply to him. And speaking of scans he had had which came back normal.

> *And I don't believe that cause I am not even sick...I don't have the symptoms.* (Do you know what the symptoms are?) *Fever (laughs) that's the biggest one and I don't have that.*
>
> *You supposed to lose hair I think..you lose a bit more hair your hair grows slow or something like that.*
>
> *Ya hallucinations. I don't have that.*

Here-and-now experience of psychosis. Although *Mandla* had been voicing his frustration and annoyance at being perceived as ill, he was exhibiting some positive symptoms during the interview. During the interview there was a short time where he had still been experiencing auditory hallucinations. With the limited insight into his illness *Mandla* did not experience that moment as unusual.

He also experienced that moment as a reality-based interaction with his friend. Although this interaction he had was brief the relationship between him and his friend is one of a strong bond. To the degree that if one is ill then so is the other. Furthermore his experience of auditory hallucinations is a comforting one. He describes an interaction with a close friend, thus the auditory hallucinations are friendly and non persecutory in nature.

> *My friend thinks he's sick I'm sick. My friend, he is my best friend. We chill together ya. We started smoking dagga together and stuff like that so ya.*

> *I don't know man (pause) he made a joke just now that's all.* (Just now?) *Ya*

Conclusion

In this chapter a detailed analysis was conducted on the two participants who were interviewed. Following the IPA method each transcript was analysed where themes were detailed as well as sub-themes. Pseudonyms were used for participants in keeping with confidentiality.

Each participant was describes with regards to their age and the primary diagnosis given to them by the multi-disciplinary after presenting them at a ward conference.

Participants had themes and sub-themes that were unique to their current experience. Direct quotations from the participants were used throughout the chapter in order to highlight an element of that particular experience for individuals. Both participants were able to speak of the Zulu culture and the manner in which they form their masculinity within the culture.

Furthermore both participants had strong views on current hospitalisation at Weskoppies hospital and denied that they were in any way experiencing mental illness.

Chapter 6: Discussion

Introduction

An appraisal of themes will be discussed in this chapter. Overarching themes will be identified to see what the participants have in common and what experiences are unique to teach of them. These themes will be identified and discussed taking into account literature that has been discussed in previous chapters.

Furthermore a critical discussion will be detailed on the recommendations of research of this manner as well as the strengths and limitations of the study.

Appraisal of themes

Experience of the Zulu culture. Both participants place themselves firmly within the Zulu culture sharing their experiences of being a part of the culture. The common thread amongst participants is the significant manner in which identity in the culture shapes their experiences. In this regard there is a strong allegiance to culture and ethnic identity for both participants, as well as an overriding element of respect within and amongst Zulu people. In this regard to be respectful is an integral part of the culture and to be respectful to elders is of the utmost importance.

As noted by De Haas & Zulu (1994) amongst Zulu people exists a strong ethnic identity. With this they noted distinct practices and certain modes of being that are only specific to Zulu people. The theme of respect within the Zulu culture is common amongst all three participants (Mchunu, 2005 & Ntsimane 2007). Furthermore for both participants to be respectful to elders and those older than themselves is of importance (Ntsimane, 2007).

The experience of masculinity. For *Mandla* masculinity is formed by the manner in which the head of the household interacts with the rest of the family. It is thus within the family unit that being a man derives its meaning for him. Furthermore he relates to his

masculinity by being a father and husband. It is predominantly in this context that being a Zulu man derives its meaning for *Mandla*.

Mandla's experience in this regard is supported in literature by Mchunu (2005). In this regard the head of the household is to be respected and to assert their will on the rest of the house. Furthermore young men are brought up to maintain the behaviour they observed in their childhood homes when it is their turn to become husbands and fathers (Mchunu, 2005; Mzulwini, 1996).

Mzwandile experiences the formation of masculinity in the Zulu culture through the authoritarian and stern nature of these men. Thus for him to proves ones masculinity is the ability to assert a level of power over others. Furthermore masculinity is formed through the firm nature of men. In this regard to compromise on ideas, and to allow discussions over various opinions, show any form of leniency would thus emasculate a Zulu man, as masculinity is formed through the rigid and uncompromising nature of men.

Mzulwini (1996) supports *Mzwandile* ideas on masculinity when stating that Zulu men are observed as stern and authoritarian. Additionally in describing Zulu people and more notably Zulu men as disciplined Uchendu (2008) illustrates the importance held in masculinity through rigid norms for men and the culture as a whole.

Having described the formation of masculinity in the Zulu culture though authoritarian and stern norms, *Mzwandile* contradicts this idea by stating that Zulu men are lazy. Thus it appears that there is a standard to be reached to be considered masculine and dominant in the culture. However to be authoritarian, stern and disciplined in the formation of one' masculinity is challenging to obtain. This is observed in his contradiction of Zulu men; in that they are lazy and therefore not reaching the ideal of being the authoritarian, powerful and stern Zulu man.

Self identity within the culture. A strong theme identified amongst both participants

was self identity as a Zulu man. Although they both identified strongly with this theme, each participant had a distinct experience of the self in the Zulu culture.

For *Mandla* his self identity as a Zulu man is strongly placed in language. Although he is Siswathi in ethnicity the formation of his own identity through language is integral to being a part of the Zulu culture. Therefore for *Mandla* to be able to communicate expressively through words, aids in his self identity in the culture. There is a connection for him to Zulu people through words and the ability to join over the same language. *Mandla's* self identity through communication is supported in literature by Campbell and Maré (1995). In this regard self identity as a Zulu person occurs when communicating with other Zulu people in isiZulu.

Although identifying himself as a Zulu man *Mzwandile's* experience is of not living up to the legacy of the Zulu man. Furthermore he experiences feelings of unworthiness and shame. He identifies as Zulu man however he does not believe that he stands up to other Zulu people due to what he feels are past failings. Past failings include having stolen cars. In describing Zulu men as honourable he becomes a useless Zulu man, as honourable Zulu men would not steal cars. This is noted in Uchendu (2008) where to not live up to the ideals of the culture lead to experiences of shame and embarrassment.

Relationship with family members. Both participants had significant relationships with family members as a result of their current admission to Weskoppies hospital. Both participants come from significantly different familial backgrounds. Where *Mzwandile's* family had been less supportive of him due to repeated criminal activity, *Mandlas's* family had been supportive of him through his repeat readmissions to psychiatric hospitals.

Of significance is that *Mandla* has been openly verbally aggressive and hostile towards family members throughout psychiatric admission, and his family remains supportive of him. *Mzwandile* on the other hand through his criminal activity and current

admission has no support from his family and has been asked by the relatives where he was living to leave their home once he has been discharged from the hospital.

The experience of a supportive family. *Mzwandile* and *Mandla* appear to be at a polarity with one another with regards to the experience of a supportive family. In this regard *Mzwandile's* family was not supportive of him and Mandla experiences a great deal of family support.

Mandla's family is supporting of him in that they have on numerous occasions attempted to get him an admission to a hospital when they noted that he was becoming ill. In this regard *Mandlas's* family appears to be involved in his life to a great degree. This involvement appears to be further heightened due to his repeat admissions to psychiatric illness. During these periods of his repeated admissions to psychiatric hospitals his family has banded together forming a protective bond around him. This is noted in them being present at the hospital throughout his admissions showing their support and concern for him.

Throughout his admissions his parents appeared to experience anxiety over his illness. Through the various places he has been including Weskoppies hospital there appeared to be no shift in his illness resulting in him being readmitting often. In the course of their feelings of frustration, the experience of helplessness and desperation was imminent. Thus in the hopes of getting their son well his family tried alternate forms of healing in the form of prayer at a church.

Mandla's family's' reaction to his illness and wellness thereafter has been noted in the works of Adam et al. (2000). In this regard families are able to provide a significant amount of support for family members diagnosed with schizophrenia. Emotional support is provided by family members as well as financial support. Angermeyer et al. (2004) further supports the discussion on *Mandlas's* family in stating that although families are supportive, burdens may arise. Thus in *Mandla's* family possible burden arises in the form of disruptions

to the family through his repeat admissions to psychiatric hospital. Clark et al. (2011) state that caregivers supporting family member diagnosed with a psychotic disorder may face numerous challenges. In Mandla's instance challenges faced by his family include; having to maintain the family unit through his repeat admissions as well as being parents to a young adult with a potentially debilitating psychiatric disorder. As mentioned previously his parents in their experience of frustration turned to alternate forms of healing through prayer. This is supported by Hedden et al. (2008) who report that spiritual healing is sought out by religious people in an attempt to cure mental illness.

The experience of strained family relationships. Strikingly different from *Mandla's* experience of a supportive family *Mzwandile* appeared to have a family that was not supportive of him at the time of his admission to the hospital. Although he didn't elaborate further he made mention of having lived at his grandmother's before admission and subsequently being told by his family members that they do not want him back.

Mzwandile appeared to experience rejection from his family as they have openly stated to him that they do not want him to return once he has been discharged from the hospital. Furthermore there is the experience of being isolated from everyone around him as he did not receive visitors during his admission at the hospital. In conveying this tense relationship with his family *Mzwandile* appeared to also experience feelings of guilt and remorse. These feelings could be a result of the criminal activity he was a part of and the burden it placed on his family. With his admission to Weskoppies hospital it would appear that his family had reached a level where they were unwilling to take responsibility any further.

In this regard it would appear that he became a substantial burden to his family who were no longer able both emotionally and physically to care for him. It could be hypothesised that the objective burdens of financial expenses needed for his treatment, bizarre delusions

and behaviour may have impacted his family to the degree that they were no longer willing to have him in their home. *Mzwandile* comes from a poor family background. The financial expenses of seeing him whilst in police custody and in the hospital could have taken a great toll on the family.

Although his family is supportive of him, *Mandla* experienced a strained relationship with his family as he did not believe he had a mental illness. Furthermore he experienced annoyance at his family for having had him admitted to Weskoppies hospital. For *Mandla* his family's presence at the hospital evoked in him a great deal of frustration. Having his family show their concern for him while he is in the hospital increases his feelings of frustration. This being because he does not believe he has a mental illness or that his admissions to hospitals have been warranted. Additionally being admitted to the hospital involuntarily puts him at odds with his family as he experiences a sense of betrayal from them. Thus *Mandla's* feelings of betrayal, irritation and anger towards his parents could be the consequence of him not feeling heard by his family with regards to not having a mental illness.

According to Clark et al. (2011) parents whose children are young adults and diagnosed with a psychotic disorder are more likely to experience a range of feelings. These feelings include helplessness, guilt and the regret that they had not sought treatment for their children earlier. In *Mandla's* instance his family experienced helplessness through his repeated admissions to hospitals. Clark et al. (2011) further states that these parents of young adults diagnosed with a psychotic disorder are more likely to seek out treatment once their children have been diagnosed with a mental illness. Different to *Mzwandile's* family, *Mandla* comes from a middle class family background and they experience no financial burden in obtaining treatment for him. In this regard *Mandla's* family have attempted on numerous occasions without financial difficulty to obtain treatment for him.

For *Mandla* it is nuisance to be in a psychiatric hospital as he experiences himself as

being well. Whereas it appears that his parents have sought treatment measures in order to get their son better. Furthermore being taken for alternate forms of healing is not warranted for him as he does not see himself as a person who requires healing.

The experience of hallucinations and delusions. Both participants on the time of interviewing were presenting with psychotic behaviour. Participants were able to engage with the interviewer and the psychotic behaviour was only noted through probing. This is confirmed by Coltheart et al. (2007) where they state that persons diagnosed with psychotic disorder are able to engage in interviews coherently and logically. Delusional content or other psychotic symptoms may only become apparent when specific questions with regards to the symptoms or bizarre behaviour are explored.

Symptoms varied amongst the two participants. *Mzwandile was* experiencing delusions of reference and grandeur. *Mandla* on the other hand exhibited symptoms of auditory and visual hallucinations. The spectrum under which delusions can fall under is quite significant. Thus according to Coltheart et al. (2007) the more bizarre the delusion is the more likely an individual will be diagnosed with schizophrenia. Thus in *Mzwandile's* instance he was given the diagnosis due to the bizarre quality of his delusions. Sue et al. (2010) and Suri (2011) reported that the most common types of hallucinations are both auditory and visual hallucinations. *Mandla* experienced both auditory and visual hallucinations.

An overlapping theme amongst both participants was the denial of mental illness. This is confirmed in literature by Amador et al. (1991) who state that persons diagnosed with schizophrenia may exhibit an unawareness of their current condition. Terms they used to describe this unawareness include evasion, defensive denial, sealing over and poor insight. Langdon and Ward (2009) are of the opinion that persons diagnosed with schizophrenia's lack of awareness can be understood from two perspectives; the deficit and non deficit

approach. The former approach states lack awareness being due to decreased neuropsychological ability. The latter approach states that the lack of awareness amongst persons diagnosed with schizophrenia is due to the threatening nature of having to be introspective on the negative parts of oneself. To be introspective on these negative parts of oneself may be too threatening and thus they are avoided (Langdon & Ward, 2009).

Although both participants denied having mental illness they experienced their feelings towards being labelled as mentally ill in different ways. Both participants have difficulties in their vital contact with reality. This is described by Minkowski (1927) when stating that when there is a loss of vital contact with reality persons diagnosed with a psychotic disorder live in their own realities. In this regard they are unable to preserve their own ideas without this affecting their ability to make sense of this reality.

Mzwandile strongly believes that he is feared and envied by people due to the amount of power he has. Thus from a cultural perspective he experiences feelings of living up to the ideal of being a Zulu man through having strength and power. Furthermore the envy that he describes speaks to his experience of feeling like a great man. A man whom is spoken about by others due to the immense power he experiences having. Binswanger (1956) spoke of the term extravagance which he described as holding an exaggerated notion of an ideal existence. This is noted in *Mzwandile's* delusions of grandeur. For him the exaggerated notion of an ideal existence speaks to feelings he wants to encompass. These feelings are far removed from the reality he experiences currently where he does not live up to the ideal, insofar as being rejected from family, being unemployed and having a criminal past.

He also experiences resentment at the hospital for keeping him for no good reason. Especially as he experiences being a powerful man whom is feared and describes this as the reason for being kept at the hospital. This speaks to the grandiosity of his delusions and him feeling persecuted by the hospital. This became a prominent feature noted in his interview.

This has been detailed by Jaspers (1923/1963) where he speaks of the *ununderstandability* being the hall mark of psychoses. In this regard the grandiosity or persecutory nature of delusional content speaks to *ununderstandability* being.

Mandla experiences a great deal of frustration when labelled as a person diagnosed with schizophrenia. It appears that he feels that he needs to prove that he is not mentally ill, and so does this by listing what he feels are symptoms of psychosis including losing one's hair and having a fever. This calls to feelings of desperation that he experiences in an attempt to prove to everyone around him that he does not have schizophrenia as everyone around him says that he does.

Mandla strongly denied having mental illness although objectively hallucinating during the interview. The symbolic meaning behind having a friend whom he speaks to and whom he describes as having great camaraderie with is integral in understanding his illness. *Mandla* feels isolated from his family through his perceived betrayal of them, having a companion whom he does everything with fulfils that role in his life. In this regard he is not as isolated and he experiences being in relation with a person who believes him and will not betray him as he feels his family has.

This is supported by Suri (2011) who states that hallucinations experienced are not fabrications but rather symbolic messages that describe an individual's current experience. This is evidence in the tense relationship noted above with family, and feelings of betrayal and frustration towards them. Having to acknowledge that he does have a mental illness and that he needs to be in the hospital may be too threatening for him to acknowledge. Thus as noted by Langdon and Ward (2009) his lack of awareness of his diagnosis may be due to the threatening and difficult manner of being introspective of the negative parts of himself.

None of the participants reported on a link between culture and mental illness in the form of either some form of spirit possession, *ukuthwasa* or *amafufunyana*. For both

participants culturally, mental illness is nonexistent. This is in contrast to Washington (2010) who states that Zulu people identify disorders; including schizophrenia psycho-spiritually rather than it being a mental disorder. For *Mandla* it is possible to describe the disorder in the culture by its name; however it does not change for both of them that mental illness does not exist in the culture.

Measures to enhance qualitative research

Debate exists among researches on the ability to produce qualitative research that is sound. Willig (2013) states that to systematically evaluate of qualitative research poses a challenge. Of note the contextual nature of qualitative research and the meaning derived thereof poses difficulty in the appraisal of it.

Guba detailed four criteria that ensure trustworthiness of qualitative research (Holland & Kawulich, 2012; Shenton, 2004). These include credibility, transferability, dependability and confirmability. These criteria were kept in mind throughout the research process.

Credibility. Guba states that credibility is one of the most important factors in establishing the trustworthiness of a study (Shenton, 2004). In the attempt of accurately recoding phenomena a number of factors are considered. These factors include; the adaption of well established research methods, the development of an early familiarity with the culture of particpants approaches to ensure the honesty of participants, iterative questioning, peer scrutiny and the researcher's reflective commentary as well as thick descriptions of phenomena under scrutiny (Shenton, 2004).

Interpretive phenomenological analysis was chosen as the research method for this study. It is a well established and researched method and methodology. In the development of an early familiarity with the culture of participants, Guba speaks of there being a relationship of trust between all parties involved in the research (Shenton, 2004). I am a first language speaking Zulu person. This greatly aided in the rapport building between myself and

participants as well as forming a level of trust with the men interviewed.

In ensuring the honesty of the participants it is important in the information sharing part of the research at the beginning that participants are given the opportunity to decline. In this regard one can make certain that participants are genuinely interested (Shenton, 2004).

At the beginning of the study I informed participants that if they wished not to participate they were not obliged to. *Mzwandile* in particular was hesitant to partake in the study as he felt it would lengthen his admission time at the hospital if he was to disclose any information. I spoke to him about confidentiality, but I also posed to him that he didn't have to participate if he felt hesitant; this helped build rapport with him and put him at ease.

Iterative questioning is used in order to determine whether participants are being dishonest. This is employed by returning to previously spoken material and rephrasing the questions (Shenton, 2004). As both participants were both psychotic during the interview, it was at times difficult to be certain about dishonesty on their part for a possible secondary gain. However through returning to previously spoken material, the consistency in both men's use of language in expressing of their thoughts helped in noting their honesty. Peer scrutiny of a research aid in checking whether the research is sound. Furthermore a fresh perspective allows to question the assumptions investigators have made (Shenton, 2004). It was challenging with both participants to fully grasp meaning in their presentation of schizophrenia during the interviews. The perspective of other colleagues helped in aiding my understanding of psychosis and how meaning can be formed. Furthermore my supervisor gave me different perspective in how to think about the presentation of psychosis.

The reflective commentary is an important element to the credibility of research. My reflective commentary is detailed both personally and on the epistemological dimension. This will be detailed further on in this chapter. The background, qualification and experience of the researchers are integral as they are the chief instrument of data collection and analysis

(Patton, 2002). As a first language Zulu speaker I was able to speak with the participants in their first language and transcribe duly. Furthermore I went to an English school where I learnt language as a first language. Thus I was able to adequately translate into English the verbatim Zulu transcripts.

I am currently enrolled in the Clinical Psychology Masters course at the University of Pretoria. The theoretical knowledge obtained in my training helped to better understand and familiarise myself with the population of persons diagnosed with schizophrenia. Shenton (2004) states that it is also important that the investigator mentions the various places they got clearance from in order to commence research. For this research I had to obtain three different approval letters. As my research was conducted at Weskoppies hospital, a teaching hospital affiliated with the University of Pretoria, I first had to get ethical clearance from the Faculty of Health Sciences ethics committee. Once I had received the approval from them I sent my ethics approval to the CEO of Weskoppies hospital requesting to conduct research at the hospital with proof of ethical clearance from the Faculty of Health Sciences. Following an approval letter from the CEO of Weskoppies hospital, I then had to gain ethical clearance from the Faculty of Humanities research committee and ethics committee. After they had given me clearance I was then able to commence with my research.

Member checking refers to checking the accuracy of the data. It also entails authenticating the emerging themes that materialise in the research (Shenton, 2004). My transcripts were verified by several other first language Zulu speakers in order to determine the accuracy of my transcripts as well as my translations. My supervisor assisted me with themes that emerged and the inferences that I was making. Throughout the case-by-case analysis of transcripts the IPA steps were followed. In reporting in such a systematic manner it helps readers to better understand and engage with the cases (Shenton, 2004).

Transferability. Transferability refers to the possibility of the study being applied in

a different situation (Shenton, 2004). It is important that for this to be possible the parameters of the study need to be clearly defined. This study took place at Weskoppies hospital. A psychiatric hospital situated in the West of Pretoria. There is a large clinical population at Weskoppies hospital and for this study persons with schizophrenia were chosen. Initially several men were screened for the research however only two of the participants met with the criteria needed to commence the study.

Interpretive phenomenological analysis was employed as both method and methodology. An individual interview was conducted with each participant. There was no limit to the length of time of the interview however it was important that a variety of questions were posed to participants. These were constructed by me and my supervisor, and prompts were included in the semi-structured interview. There was not a set time period over which my data was collected. There was staff at Weskoppies who were aware of my study, when they thought that there was a participant who appeared to meet the criteria they would inform me. If they met all the criteria I would hand them the letter of invitation for the study. It was also here that we would explore any hesitance, or ambiguity they were experiencing.

Dependability. Dependability of the research refers to the stability of the research findings over a prolonged period of time (Holland and Kawulich, 2012). A close connection exists between credibility and dependability. Shenton (2004) is of the opinion that the clearest way for a study to be dependable is to provide detailed descriptions throughout the research. This allows for the study to be repeated by potential researchers. Throughout this study there have been detailed descriptions of the research process. Detailed descriptions include the step by step account of the research method and methodology chosen, IPA. Furthermore a detailed description was given with regards to the ethical approval needed to conduct research of this manner at Weskoppies hospital.

Confirmability. Shenton (2004) argues that of importance, research findings are the

results of the experiences of participants rather than the preferences of the researcher. A reflective diary was kept throughout the research process. Furthermore my supervisor would challenge assumptions I had as themes were emerging so as to ensure it was the experience of participants rather than my own assumptions.

Reflexivity

According to Willig (2009) reflexivity becomes integral in research as it recognises the researcher's capacity to shape and influence the research process on a personal level but as well as a theorist. In the following section both personal and epistemological reflexivity will be detailed considering me as a student, a Zulu woman and a researcher.

Over the course of the research I kept a reflective journal. In this journal I would reflect on the research process as a whole, as well as journaling my highs and lows during this process. On meeting the participants I would write down ideas and impressions about the interview, furthermore through listening to the recording and transcripts ideas came to me on the research process as a whole.

Personal dimension. From the inception of the research I was inspired. Inspired by the field of psychology and inspired by conducting research with a population that I have always deemed as misunderstood. Misunderstood by public perception, media representation and at times what I felt was the health sciences. Conducting research with this population meant for me that we could consider this at times debilitating diagnosis differently.

Riding on this inspiration I knew that I would have to be select with regards to the ethnicity of this population. As thrilling as it would have been to conduct this type of research with many different types of individuals of different ethnicities, I knew this would not be possible. Since the aim of the research was to gain better understanding of the lived experience of each participant diagnosed with schizophrenia, a homogenous group of participants needed to be selected. Thus the decision was made on the Zulu male population.

As a young student I was wary that participants would not be willing to engage with me, or that they would have been overly cautious. It was when they engaged with me that I realised being able to converse with them in our first language put them at ease. I also noticed how participants were also put at ease when I disclosed that I was also Zulu.

I was cautious that asking men about how they define their masculinity within a culture I am a part of would be met with resistance. My fear as a young Zulu woman was that I would be deemed disrespectful by participants in asking questions that probed into the personal lives of men. I felt more in particular with *Mzwandile,* who was substantially older than me, that he may assume that I am disrespecting his authority as an older man in the culture.

However I was surprised to note that the interviews went on with no resistance from either participant. In truth the more participants spoke of cultural identity, difficulties in family relationships and how they shape their masculinity in line with the Zulu culture the more at ease they became. The ease at which they felt they could speak during the interview allowed for a rich description of their lived experience as well as a better understanding of their individual experiencing of being diagnosed with schizophrenia. As a woman conducting research with men I considered the impact that this may have had. Although none of the participants had any objection it was difficult for me to listen to *Mandla's* opinion on women and how they should be treated by their partners. This made it difficult for me to connect with him throughout the interview. This power differential between men and women and the force of power that he believes is a part of the culture was difficult for me to hear. I found myself wanting to disagree with him, to state it was rather an individual opinion rather than a part of the culture in the manner that he was saying.

Significantly with regards to Mandla's interview I often found myself overriding his experience, stating as mentioned that it was a rather an individual opinion of his rather than

the views of the culture as a whole. The danger in these ideas I started having was that *Mandla's* experiences became overshadowed by my own experiences due to the disconnect I felt with him about comments he had made.

Being a Masters student I retrospectively see I was not fully prepared by the degree that these men would still be psychotic when I met them. Thus when meeting *Mzwandile* I most likely lost a lot of valuable information due to the grandiose delusions that were present and the degree to which they were present. Whereas by the time I had seen *Mandla* I was more prepared for this possibility and was thus able to illicit more information from him while experiencing visual hallucinations.

Epistemological dimension. I had chosen to conduct research on this population for two reasons; firstly as a Zulu woman I understand the language and the nuances of the Zulu culture. This would give me another opening as to better grasp the experience of participants. The second reason I chose this population involved gender. I wanted to better understand the cultural perspective from a male perspective.

Being a female from this culture I have a female perspective on the culture, in choosing the male population I would gain new insights that I may not know fully. Furthermore this was chosen to better understand the differences, if there are any, about the experience of mental illness along the backdrop of culture.

Phenomenological research of this manner has not of yet been conducted with this population. This would allow for more research to be conducted at a later stage. In choosing my criteria for Zulu men however I came across difficulties with finding participants. Had I chosen a different cultural population I may have gained richer data as they may possible have been more participants to choose from. Several participants were screened for the research and although Zulu speaking; Siswathi, Xhosa and Ndebele, they were not from the Zulu culture. Furthermore with the difficulty in finding participants

Mzwandile was added to the study although he was three years past the initial age criteria.

Inititially I had interviewed three participants in order of; *Mzwandile* to *Themba* and then to *Mandla*. Furthermore I analysed them starting with *Mzwandile* then *Mandla* and lastly to *Themba.* I was already under the impression during transcribing that *Themba* may have not fully met the criteria for the research. Having gone back to *Themba's* treating psychologist I realised I had made an error in identifying his primary diagnosis and thus he could not be used for the research study. With the two participants left for the research study I felt that not having *Themba's* transcript would have an impact on the research process.

I felt that with only two participants the richness of data would be lacking somewhat. However taking into account that these were the only participants available to me at the time transcripts were read and re-read in order to gain the richness in data that I felt was lacking with a sample size of two participants.

As I interviewed the participants I started thinking about the ways in which each of them differed and how they were similar. Thus with each interview I was able to ask certain questions differently in order to ensure that I was tapping into the participants unique experience rather than being overly consumed by the manner in which participants answered similarly.

Strengths and limitations of the study

Methodology. IPA is explorative in nature and it has as its focus the subjective experience of participants and the manner in which they form meaning in their lives. An array of methodology could have been utilised for this study.

Grounded theory could have been utilised for the study. Generating theory from data or the modification of existing theory is the core of grounded theory (Nieuwenhuis & Smit, 2012). This methodology would have been beneficial in the building up of theory with regards to participants' experiences of hallucinations and delusions in relation to culture,

familial relationships and manhood.

Discourse analysis may have also been utilised as methodology for the study. Discourse analysis has as its foundation the manner in which social reality is constructed (Coyle, 2007). Having used this method in the study we would have been better able to understand how participants see themselves in the world. Furthermore this type of research would have been beneficial in understanding how participants come to understand and construct themselves in the world with the diagnoses they have been given.

IPA was chosen as the most beneficial methodology as it allowed for an understanding of the subjective experience of participants. Thus through IPA, the lived experience of each participant's hallucinations and delusions, perceptions of culture and masculinity and family relationships could be navigated through.

Participants. The number of participants used for the study was limited. A larger sample could provide additional insights in a manner that this research partially accomplished. Furthermore this research focused on men who identified themselves as being from the Zulu culture. The limited number of participants does not appear to be representative of the chosen population of participants. Future research could consider all males who are Zulu speaking even if they don't identify with culture. In this manner additional information may be procured and comparisons made.

Culture. Both participants identified themselves as being Zulu. *Mzwandile* is a Zulu man from a Zulu family. Whereas *Mandla* identified as being a Zulu man, as he speaks the language. This allowed for a greater understanding of each participants own understanding of the culture, and the similarities and differences they both had with regards to the culture. The difficulty however was obtaining enough Zulu men to participate in the research.

Additional research of this nature would need more Zulu participants, this would allow for additional information to enrich the understanding of the lived experience.

Furthermore once-off interviews proved to be unfavourable. Follow up interviews with participants would allow for detailed description of participants' experiences as well as clearing up any information that may not have been clear to the researcher.

Conclusion

The themes illustrated in this chapter are in line with literature in the literature review. Themes identified were illustrative of both participants' individual experiences which were in line with the aim and objectives of the research study. In keeping with the objectives of the research study the personal experience of hallucinations and delusions and the meaning thereof for participants was noted for both participants. The meaning revolved around being a powerful, feared man for one participant. For the other participant the emotional meaning of hallucinations and delusions centred on needing a companion whom they can trust and who is supportive of them.

Although both participants made no link between Zulu culture and symptom presentation both participants spoke of culture and manhood. Themes of masculinity and power were present in the hallucinations and delusions of one participant. Although manhood was not accounted for in the objective and aims of the study this became an integral experience for both participants in diverse ways. A stronger emphasis on the formation of manhood and culture and the hallucinations and delusions of participants should be considered for follow up research of this nature.

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Appendix A- Invitation to participate in the research

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

Faculty of Humanities
Department of Psychology

Title of Study

Hallucinations and delusions of schizophrenia among Zulu men: an interpretive phenomenological analysis

Invitation

We invite you to participate in a research study. This information leaflet will help you to decide if you want to participate. Before you agree to take part you should fully understand what is involved. If you have any questions that this leaflet does not fully explain, please do not hesitate to ask the researcher, Phumelele Masondo.

Purpose of Study

This study will be conducted at Weskoppies Hospital and is about how Zulu men who are diagnosed with Schizophrenia understand and experience hallucinations and delusions. About five men will participate in this study and you are a very important source of information for this study.

Procedures

This study involves conducting interviews with participants. If you take part in this study, the researcher, Phumelele Masondo, will have an interview of about an hour with you. Phumelele will ask you questions specifically about how you experience hallucinations and/or delusions and what it means to be a Zulu man. Because the study is interested in your unique experience, there are no right or wrong answers

Risks and discomfort involved

There are no immediate risks in participating in this study. If there are any questions that you are uncomfortable with, you do not have to answer them if you do not want to. If you feel that due to our conversation you would want to consult with a psychologist, Phumelele will inform one of the psychologists at the Department of Clinical Psychology and one will be made available to you.

Possible benefits of the study

There are no incentives linked to this study and there are no direct benefits to you either. Your participation in this study will enable researchers and medical professionals to understand your experiences better. This may in turn help us to develop more effective therapy.

What are your rights as participant?

Your participation in this study is entirely voluntary. You can refuse to participate or stop at any time during the interview without giving any reason. Your withdrawal will not affect you in any way.

Ethical approval

This study has received written approval from the Research Ethics Committee of the Faculty of Health Sciences at the University of Pretoria as well as the Faculty of Humanities at the University of Pretoria. Copies of the approval letters are available is you wish to have one.

Information and contact person

The contact person for the study is Phumelele Masondo.

Further clarification can be obtained from the Faculty of Health Sciences Research Ethics Committee. Tel: 012 354 1330 Fax: 012 354 1367 HW Snyman Building (South) Level 2-34

Compensation

Your participation is voluntary. No compensation will be given for your participation.

Confidentiality

All information that you will give will be kept strictly confidential. Once we have analysed the information no one will be able to identify you. Research reports and articles in scientific journals will not include any information that may identify you or your hospital.

Appendix B- Informed consent

CONSENT TO PARTICIPATE IN THIS STUDY

I confirm that the person asking my consent to take part in this study has told me about the nature, process, risks, discomforts and benefits of the study. I have also received, read and understood the above written information (Information Leaflet and Informed Consent) regarding the study. I am aware that the results of the study, including personal details, will be anonymously processed into research reports. I am participating willingly. I have had time to ask questions and have no objection to Participate in the study. I understand that there is no penalty should I wish to discontinue with the study and my withdrawal will not affect any treatment in any way.

I have received a signed copy of this informed consent agreement.

Participant's name:

Date…….
Place……..

Participant's signature ……...…

Investigator's name:

Date…….
Place……..

Investigator's signature ……..

Witness name:

Date…….
Place……..

Witness's signature ……

Appendix C- Interview protocol in English

1. How would you describe being Zulu?

Prompt: How would others know/recognize you as coming from Zulu culture?

2. How would you describe what it means to be a Zulu man?

Prompt: Do Zulu men differ from other men? How are they similar?

3. How was it for you to receive a diagnosis of schizophrenia?

Prompt: How did you make sense of the diagnosis given? How did it affect your life?

4. What are the symptoms you experience as a person diagnosed with schizophrenia?

5. As a Zulu man what does it mean for you when hallucinations/delusions occur?

Prompt: When the (symptoms) occur what personal identity comes with it for you?

Prompt: How does your community relate to you because of the (symptoms)?

Appendix D- Translated transcript of Mandla's interview

Interviewer: Don't mind the recorder we are just going to talk

Participant: Okay

Interviewer: Where are you from?

Participant: I am from Northlane Park

Interviewer: Whereabouts is that?

Participant: It's in Kempton Park

Interviewer: It's in Kempton Park

Participant: Near Tembisa

Interviewer: Okay how old are you?

Participant: I am 19 this year

Interviewer: 19? This year?

Participant: Yes

Interviewer: Are you married, girlfriend?

Participant: I don't have a girlfriend...I am not married

Interviewer: Okay..You mentioned that you are from Kempton Park. Where were you born? Were you raised there?

Participant: Umm...I was raised there

Interviewer: You were raised there

Participant: I was raised in Tembisa and then we moved to Kempton Park

Interviewer: How come?

Participant: Oh well we found a house and we bought a house and stand and built there

Interviewer: So your whole family

Participant: And I moved school

Interviewer: You moved school..so you moved school from Tembisa to Kempton Park?

Participant: Ya

Interviewer: Okay..and are you finished at school?

Participant: I am busy with Matric

Interviewer: You busy with Matric? Okay..what school are you in?

Participant: Hoërskool Kempton Park

Interviewer: Hoërskool Kempton Park...and you guys speak Afrikaans at Hoërskool Kempton Park?

Participant: Yes we speak Afrikaans

Interviewer: Do you guys speak Afrikaans first language or second language

Participant: First language

Interviewer: First language...so it's better to speak Afrikaans?

Participant: Yes we speak Afrikaans

Interviewer: Okay.. and have you ever worked?

Participant: I have worked at the ice rink

Interviewer: At the Ice rink?

Participant: Yes

Interviewer: Okay..what do you do as working at the ice rink?

Participant: As an official

Interviewer: What is the job of an official?

Participant: You help people on the ice..like you, when they fall you help them up and you kind of keep the rules on the ice

Interviewer: Oh okay..How long were you employed there for?

Participant: Well I have been working on and off..I have been working there four years

Interviewer: Four years

Participant: On and off

Interviewer: Why on and off

Participant: Because when I am working at the ice rink..sometimes I work sometimes I don't work.

Interviewer: Okay..okay so I am going to ask you a couple of questions about culture and I wanted to know what you think about culture and we will go from there. Okay?

Participant: Okay

Interviewer: So how would you describe being a Zulu?

Participant: Zulu..its a... it's a special agreement of doing things in a manner that is respected of

Interviewer: Can you explain to me a bit more what you mean by respected of?

Participant: Like ummmm..We are not disrespectful of people..and we know our adults

Interviewer: We know our adults?

Participant: Ya

Interviewer: And when you speak of adults..you speak of people who are older than you?

Participant: Older than you

Interviewer: Does it depend whether they are in your family or not?

Participant: No it doesn't depend

Interviewer: Okay...Just so I understand you say that we respect our adults regardless of whether they are family or not.

Participant: Ya

Interviewer: Okay..How..how would you describe being a Zulu man?

Participant: Man..The best men in the world! Well we work firstly and we have rules. And we know how to control our women

Interviewer: Okay so can you explain to me what you mean by you guys know how to control your women?

Participant: We fuck them up (laugh)

Interviewer: You fuck them up?

Participant: Yes (laughs)

Interviewer: How do you fuck them up?

Participant: Well when they come late at home then they know what must happen

Interviewer: So when you say you know what must happen and you fuck them up..can you give me an example?

Participant: Like if my mom comes home at a time that my dad said she mustn't come..she will get slaps. You understand

Interviewer: Okay..I understand. Would you do the same thing with your woman

Participant: Ya

Interviewer: If she was late?

Participant: Ya

Interviewer: So I hear that respect is a very big thing for you..and that as a Zulu man respect is a very big thing for you.

Participant: I am Swathi, but a Zulu man

Interviewer: Are you Swathi

Participant: Yes

Interviewer: Oh okay but you can speak the language?

Participant: Ya I can speak Zulu but not Swathi

Interviewer: Not Swathi. How come you can speak Zulu?

Participant: I don't know Swathi

Interviewer: You don't know Swathi

Participant: I am from South Africa

Interviewer: You are from South Africa. And so did you grow up alot with Zulu understanding of things or a Swathi understanding of things?

Participant: I grew up with whites

Interviewer: You grew up with white people? Can you describe that for me a bit

Participant: Well I was..I was.. I used to live in Tembisa and then I used to play soccer everyday and watch cartoons..It was the best time of my life. And then when I was at 8 we moved down to the oh ya....at 8 we moved back to Kempton Parkand then I started becoming friends with everybody and then ya... I mostly have white friends.

Interviewer: Mostly white friends?

Participant: Ya

Interviewer: Okay so that's more there. So you say you are from South Africa

Participant: Ya

Interviewer: But you are Swathi

Participant: Ya

Interviewer: But if you had to think for yourself cause when we are speaking to each other.. do you see yourself more as a..if we look at the black part of you do you see yourself as a Swathi man or a Zulu man

Participant: I see myself as a Zulu

Interviewer: A Zulu man?

Participant: Because I speak Zulu

Interviewer: Because you speak Zulu

Participant: Ya

Interviewer: And do you feel that culture makes more sense to you?

Participant: I feel that Swathi as a culture is like a pattern for me

Interviewer: Like a pattern for you?

Participant: Ya

Interviewer: And how would you differentiate for yourself how it feels to be a Zulu man that you described to me and a Swathi man?

Participant: A Swathi man (pause)...You know what's going down? They always know each and every move... A Zulu man is clever..but not the best

Interviewer: Not the best. And so you feel..it sounds to me like you feel like you are from both

Participant: Ya...Something like that.

Interviewer: Something like that? Okay alright. Ummm so you are currently in this hospital,

Participant: Ya

Interviewer: And I want to know can you tell me why you are in this hospital?

Participant: I'm in this hospital because they took me for check up at Tembisa Hospital..and then 2nd of January I moved here to Weskoppies hospital. And then ..well..it' wasn't for..they say it was for dagga's induces..but I am not really sick..so I am here for nothing

Interviewer: You are here for nothing

Participant: Yes

Interviewer: So you don't really think that you are ill? You don't see the point of being in this hospital or anything?

Participant: No

Interviewer: Oh alright.. Did they ever give you a diagnosis?

Participant: They do but it doesn't make sense..cause I went for a CT scan and the CT scan must say what's wrong

Interviewer: Okay what was the diagnosis that they gave you?

Participant: Schizophrenia

Interviewer: Schizophrenia? What does that..what does that diagnosis mean to you?

Participant: Mental sick..And I am not even..I don't even use drugs

Interviewer: So for you this doesn't make sense?

Participant: Ya it doesn't make sense

Interviewer: Alright..and what do they say? They say you have this schizophrenia thing...what are they saying happens to you?

Participant: It says I have chemicals in my brain

Interviewer: Yes?

Participant: And I don't believe that cause I am not even sick..I don't have the symptoms

Interviewer: You don't have the symptoms. Do you know what the symptoms are?

Participant: Fever (laughs) That's the biggest one

Interviewer: Of schizophrenia?

Participant: Ya

Interviewer: So that's like the biggest symptom

Participant: Ya

Interviewer: For you?

Participant: And I don't have

Interviewer: You don't have any of that

Participant: Any of that

Interviewer: Oh okay. And so..what other symptoms have you heard of

Participant: Ummmm

Interviewer: Of schizophrenia?

Participant: You supposed to lose hair I think

Interviewer: Okay

Participant: You lose a bit more hair..your hair grows slow or something like that

Interviewer: And that's really about..that's all you have heard about this schizophrenia thing is

Participant: Ya

Interviewer: Okay..How would you then maybe describe...if you look at you know your very diverse culture cause you see yourself as Zulu Swathi and English

Participant: Ya

Interviewer: Umm..how do you think a Zulu man would describe schizophrenia? How do you think a Zulu man would see it?

Participant: He would say "you are sick in the mind"

Interviewer: "Sick in the mind"?

Participant: Ya..from drugs or dagga

Interviewer: Or dagga...and how would you describe being a Zulu man with a mental illness?

Participant: Well it's the same..we are all sick. So there is no difference

Interviewer: There's no difference

Participant: It depends on how you handle it..like a Zulu man (pause) he might he might disagree with that

Interviewer: Might disagree with it?

Participant: Ya

Interviewer: Like, like you disagree with it?

Participant: I don't disagree with it because I don't have one

Interviewer: You don't have one

Participant: I am a truthful person

Interviewer: Okay

Participant: So I don't have it.

Interviewer: Oh Okay. Have you ever..cause you think of schizophrenia and you say hair loss and the fever

Participant: Ya

Interviewer: Do you know any other symptoms of schizophrenia?

Participant: No that's all

Interviewer: That's all. So you have never heard of people maybe seeing things

Participant: Ya. Hallucinations. I don't have that

Interviewer: Or hearing things?

Participant: I don't have that

Interviewer: Those things are very very foreign to you?

Participant: Ya

Interviewer: Alright. Just not something you have at all

Participant: Ya

Interviewer: You said to me you had a check up at Tembisa. Can you explain to me why you went for a check up there?

Participant: Because they said..my mom said my head my head is not fine

Interviewer: Your head is not fine?

Participant: Ya. So I went there..they sent me for a check up and I stayed there for many days

Interviewer: Yes?

Participant: About 18 days and then I moved to here

Interviewer: So when your mom said your head is not fine what did she mean by that?

Participant: I don't know. She's like..she thinks I am sick. By like..I am damaged in my head... I don't know how to explain it

Interviewer: And did you ever ask her what she meant by that?

Participant: Ya. And then she says I laugh on my own stuff like that so

Interviewer: And is that something that you do?

Participant: Ya something I can do. Iwas thinking about my friends so

Interviewer: Can you explain that to me a bit? So you were thinking about your friends?

Participant: Ya I was thinking about my friends

Interviewer: What were your friends doing? Why?

Participant: Like you know times we had together (pause) so like everything and braai's and stuff like that (pause) so ya we..I was thinking about them and times like that so then ya

Interviewer: And so did she find you laughing by yourself?

Participant: Ya sometimes I laugh in the car for jokes..and then she thinks I am crazy

Interviewer: And you don't think you're crazy

Participant: No I am not

Interviewer: So when your mom thinks you're crazy what do you do?

Participant: Umm....well I tell her nothing is wrong with me (pause)

Interviewer: And then she disagrees with you?

Participant: Ya

Interviewer: Okay. Can you tell me a little bit about your family? Your mom? Your dad? And

Participant: My brother

Interviewer: Your brother. How old is your brother

Participant: 25 this year

Interviewer: 25 this year okay. What are you and your brother like? How do you guys get a long?

Participant: We get along good. He disappoints me sometimes

Interviewer: Can you explain that to me a bit?

Participant: Oh well...I don't know his disappoints because I forget all of them. But there's that kind of disappointment that he gives me

Interviewer: And how does that disappointment affect you?

Participant: (pause) I don't trust him sometimes

Interviewer: Do you find that you are mistrustful of a lot of people?

Participant: No. I trust everybody.

Interviewer: Do you?

Participant: Ya

Interviewer: Just not your brother

Participant: I trust him

Interviewer: Okay..sometimes you find it hard to trust him?

Participant: Sometimes

Interviewer: Okay. And what are you like with your mom?

Participant: Well we are best friends

Interviewer: Best friends?

Participant: Ya

Interviewer: So what's it like when your best friend tell you, you are crazy?

Participant: (pause) ya it was i can't believe..it's crazy actually

Interviewer: Is it?

Participant: Now that I think about it

Interviewer: Was it hard for you?

Participant: No it wasn't hard. She's just supposed to take me out...she took me out ad brought me back again.

Interviewer: And that wasn't very nice for you?

Participant: It wasn't nice

Interviewer: If you think of your brother..how do you think he would see mental illness as a Zulu person?

Participant: Ummm..(pause) (laughs) he would say you are sick?

Interviewer: You are sick?

Participant: Ya

Interviewer: So it's almost like you guys see it as a sickness?

Participant: Ya

Interviewer: To be mentally ill is a sickness?

Participant: Ya

Interviewer: And do you think that Zulu men are able to see that sickness

Participant: Ya they are

Interviewer: They are. Do you think they are able to seek help when they are mentally sick?

Participant: Ya (pause)

Interviewer: You think so?

Participant: Ya

Interviewer: Okay. Cause I remember earlier you were saying to me that maybe they weren't..maybe they were or

Participant: (mumbles)

Interviewer: So you think they will?

Participant: Ya

Interviewer: Okay. Alright. Ummm. So you say your mom says you sick..your dad say you were sick?

Participant: Ya both of them. They took me to Morea last year

Interviewer: Okay? And why did they take you to Morea?

Participant: So that I can get help there

Interviewer: And were you sick last year as well?

Participant: I wasn't sick they just took me

Interviewer: They just took you. So what was Morea like?

Participant: It was fun. It wasn't bad.

Interviewer: It wasn't bad. And so you going to have to explain to me a bit becaue I am not too sure about Morea. When people go to Morea what do they do there?

Participant: Well we go sing and *mpogo* that's what they call it

Interviewer: What is *mpogo?*

Participant: *Mpogo*...the singing

Interviewer: Oh the singing okay okay

Participant: And then we were..so like..we (inaudible)

Interviewer: Huh?

Participant: We drink alot of tea

Interviewer: A cultural tea or what kind of tea?

Participant: Tea

Interviewer: Just like rooibos tea

Participant: Rooibos and others

Interviewer: Okay. And what is the point of going to Morea? Is it there for you to

Participant: It's for healing

Interviewer: Healing?

Participant: And for Church

Interviewer: Did you find that healing?

Participant: Ummm I wasn't sick so I dint find any

Interviewer: Healing? But you said you enjoyed it regardless

Participant: Ya. Well it wasn't that fun but ya

Interviewer: It wasn't that fun

Participant: I wanted to go home

Interviewer: Is there anyone else around you besides your mom and your dad who that you were sick? Who thought you were ill? Anyone else in your family?

Participant: No nobody

Interviewer: Friends?

Participant: Nobody besides my friend

Interviewer: Besides your friend?

Participant: Ya..My friend thinks he's sick I 'm sick

Interviewer: Can you tell me a bit about your friend?

Participant: My friend..he is my best friend..we chill together ya. We started smoking dagga together and stuff like that so ya

Interviewer: And why does he..is it a he?

Participant: Ya it's a he

Interviewer: Why did he think you were sick

Participant: I don't know man..he made a joke just now..that's all

Interviewer: Is it? So.. he made a joke just now?

Participant: Ya

Interviewer: Okay alright. So besides that..so do you see your friend often or not really?

Participant: I see him often..I am going to him this weekend

Interviewer: This weekend?

Participant: Ya

Interviewer: And what do you guys do together?

Participant: We chill..sometimes we smoke weed..man sometimes we go out to night clubs

Interviewer: Okay. And has your friend come to see you in the hospital?

Participant: No

Interviewer: No. Why not?

Participant: I don't know.

Interviewer: Do you think they would like to come and see you in the hospital?

Participant: I don't know

Interviewer: You are not too sure about that?

Participant: I am not sure

Interviewer: So you say besides that one friend...there is no one else who thinks you are sick or anything?

Participant: No

Interviewer: Okay. Alright. Just to recap for myself so you say when they gave you this diagnosis of this schizophrenia thing it didn't make sense?

Participant: It didn't make sense

Interviewer: And as a Zulu man you say that if they got that diagnosis they would see it as being sick?

Participant: Ya..to be sick. But then it doesn't make sense because if you are not sick you are not sick. People tell the truth, and I am one of them. So now I am sick for nothing (pause) I am kept here for nothing.

Interviewer: Kept here for nothing..how long have you been here for?

Participant: I have been here since the 2nd of January

Interviewer: So you have been here for quite awhile?

Participant: Ya I want to go home now.

Interviewer: Okay it's almost like you are getting a bit frustrated being here?

Participant: Ya

Interviewer: Okay. Thank you so much for talking to me I am done with my few questions

Participant: Okay.