PERCEPTIONS AND INTERPRETATIONS ASSOCIATED WITH INDIGENOUS PSYCHOTHERAPEUTIC PRACTICES OF YORUBA TRADITIONAL HEALERS IN SOUTH-WESTERN NIGERIA: A QUALITATIVE STUDY

BY

AKOMOLAFE, ADEBAYO CLEMENT
CU022100011

DEPARTMENT OF PSYCHOLOGY
SCHOOL OF HUMAN RESOURCE DEVELOPMENT
COLLEGE OF DEVELOPMENT STUDIES
COVENANT UNIVERSITY, OTA

Being a thesis submitted to the Department of Psychology, School of Human Resource Development, College of Development Studies (Covenant University, Ota), in partial fulfillment of the requirements for the award of Doctor of Philosophy (Ph.D.) Degree in Clinical Psychology.

MAY 2013

CERTIFICATION

This is to certify that this study was carried out by AKOMOLAFE, Adebayo Clement and has been read and approved as meeting the requirements of the Department of Psychology, School of Human Resource Development, College of Development Studies, Covenant University, Canaanland, Ota.

BY

Professor Akin Odebunmi (Supervisor)	
Dr. Abiodun Gesinde (Co-Supervisor)	Date
Professor A. A. Alao (Head of Department, Psychology)	Date
Professor I. O. Ogunriola (Dean, College of Development Studies)	Date
External Examiner	Date

DEDICATION

Concluding this protracted journey has not meant as much to me as holding close to my heart those that made the journey worthwhile. Through difficult moments of paradoxical ambiguity, courageous doubt, and institutional compulsion, I kept close to my heart three women – my mother, whose sacrifices for her children were designed to give us the best opportunities to make a good life; my yet to be born daughter, with whom we shall share our lives co-creating and weaving magical journeys that need not be 'certified'; and, *above all*, my life-nectar – my 'wife' – *Lali*, whose smiles, whose laughter, whose stern femininity, and whose reality I am privileged to inhabit. In the spirit of 'finding broad themes and categories' (which defines phenomenological research), I dedicate this concluded journey to a revolutionary metaphor – to a feminine awakening: 'Lali' – my life-traveller, my daughter, my mother and the magical contours of another world now emerging.

ACKNOWLEDGEMENTS

There is a story about two monks who were walking down by a riverside in deep conversation. All of a sudden, they heard muffled cries for help coming from within the raging waters. After sighting the hapless fellow struggling to hold on for dear life, the monks dived into the water, and dragged the trembling victim to the river bank. No sooner had they done this than another desperate cry for help pierced through the sky. Again, they detected another victim and plunged into the icy cold water to pull her out. However, as before, no sooner had they done this than another cry pierced the evening. Immediately one of the monks picked up his shoes and started to run up river – leaving his colleague baffled about his intentions. "Where are you going? There are people to be helped here!" the perplexed monk cried, his voice silhouetted by other cries for help that were now drawing his attention. His colleague, still running, turned and said: "I am going to stop them from where they are falling into the river!"

In many ways, this story is mine. In my quest to understand new ways of relating with the problem of mental disorders, I have had to 'run up the river' – by investigating new paradigms of wellbeing and seeking to discover new modalities for conceptualizing this very human behaviour. I believe this report is the beginning of new adventures in unraveling the mysteries of clinical psychopathology, and understanding consciousness. This 'run up the river' could not have been possible – by any stretch of the imagination – if it were not for the support of many people I seek to acknowledge.

My profound thanks go to my supervisors, Professor Akin Odebunmi and Dr. Abiodun Gesinde. Not only were they patient, deeply empathetic and supportive, they played strong fatherly roles in helping me negotiate my way through the chaos of qualitative research.

I am also excitedly appreciative of the warm presence, staunch support and graceful leadership of the Head of Department (Psychology), Professor Amos Alao, whose belief in my work was the lubricant that held my efforts in place, and kept my eyes on the goal of completing the study. The paternal warmth and guidance of Professor Kayode Oguntuwase will always be remembered fondly. I will never forget how you gave me a list of publications to guide my exploration of the great T. A. Lambo, whose legacy and concerns are at the heart of this work. Thank you, dearest sirs!

I am also grateful to all the members of the Department of Psychology, whose tacit appreciation of my motivations to embark on this study often manifested in form of advice, encouragement and a warm handshake when I desperately needed it. Hence, I am grateful to Dr. G. Adejumo, Dr. E. Evbuoma, Dr. J. Adekeye, Dr. Ovia, Dr. Adewuyi, Mr. B. Agoha, Mr. D. Igbokwe, Miss A. Elegbeleye, Mrs. S. Adeusi, , Mr. W. Powers, Mr. A. Solarin, Mr. O. Adesina Thank you all!

My acknowledgements could never be complete if I didn't acknowledge the influence of Professor I. Sobowale; Professor D. Popoola, whose Ockham's Razor made sure my work met all requirements of quality; Professor E. Kwofie, whose concern for my wellbeing and my family often put things in perspective; Professor C. Ogbulogo, whose revolutionary comments to me a long time ago set off the series of processes that inspired my foray into qualitative research; Dr. H. Abimbola, whose brotherly support was fuel to my passion; Dr. N. Ekeanyanwu, from whose swashbuckling presence I drew silent doses of inspiration.

I am also grateful for input from the late Professor Chinua Achebe, whose email to me encouraged me to continue towing the decolonization agenda; the great Professor Molefi Asante (Department of African American Studies, Temple University, USA), whose life story is itself motivation to explore indigenous traditions even more fervently; Professor Jean McNiff (York St. John University, UK) and Professor Jack Whitehead (Liverpool Hope University, UK), whose inspiring, unforgettable dinner table talks with me in 2011 and email correspondences helped me realize that qualitative research needs no apologies. I am thankful to Professor Peter Ebigbo, whose amazing energy and zest for life – coupled with a wonderful listening heart – influenced the trajectories of my research path.

I am deeply grateful for the support of Mr Segun Ayetoro, Mr Olumide Adesina, Mr Ayo Babatunde, Miss Ada Agada, 'Fisky', Olaolu, and Eniola – who served as co-researchers in this study. Thank you so much. This would not have been possible without you! I acknowledge my good friends, Reginald Bassey, Yinka Fadahunsi, Emmanuel Iheanacho, Manish Jain, and Charles Eisenstein – whose friendship I cherish.

I reserve very special thanks for a mentor, Professor Augustine Nwoye (University of KwaZulu-Natal, South Africa), who is probably one the last legendary links to a rich history of decolonization literature. Your attempts to craft an African psychology for Africa will live prominently in the history books. Thank you sir for sitting down with me to shape this study, and for recommending a phenomenological approach to answering the deep questions I

harbored. I also gratefully acknowledge Pastor Yemi Nathaniel, whose love and fatherly presence – in spite of a shockingly prolific schedule – was a lesson in humility and creativity!

I am more than grateful to Engineer Tokunbo Obayan and Professor Aize Obayan, whose role as parents in 'my' life is not merely anecdotal. Words fail me to express how outrageously grateful I am for being a part of your family, for sharing your journeys, and for enjoying your love. Thanks for making me more than an acquaintance and as close to a son as I could possibly get.

I am deeply grateful to Dr. David Oyedepo, to whom I am connected in heart and by privilege. This study was conducted in the spirit of adventure you so desperately seek to see manifested in your educational outreaches. Your fatherhood and deep concern for my wellbeing and future have endeared me to you in ways that defeat words. Thank you, sir, for being there, and for sharing this journey with me.

I am thrilled to share my satisfaction and content with my mothers – Mrs. Olufunmilayo Ibidapo Akomolafe and Mrs Syreena Joy Dike; my sisters – Bimbo, Ifeoma, Tito, Wendy; my big brother – Mr Leke Adeniyi; my dear 'father' and Aunt – Mr Ademola Aina and Mrs. Ayotunde Aina.

Finally, in the text above I placed inverted commas on the word 'my' to acknowledge a thrilling reality – which is that my life is not 'mine'. Degree or no, I am abundantly privileged to be a planet orbiting the solar system that is my life-nectar, wife, destiny and raison d'etre: 'Lali'. It's done. The journey is complete. Now new forever-journeys await us. Let's fly. Let's take Alethea along as well!

TABLE OF CONTENTS

CHAPTER FOUR: PRESENTATION AND INTERPRETATION OF RESULTS

CHAPTER FIVE: IMPLICATIONS, CONCLUSIONS AND RECOMMENDATIONS

LIST OF TABLES

LIST OF FIGURES

ABSTRACT

The current paradigm of modern mental healthcare delivery is defined by the prominence of psychopathological theories originating from the West. Consequently, the practice of psychotherapy and the systematic classification of the Diagnostic and Statistical Manual for Mental Disorders (DSM) have helped create a monoculture of healing that is insensitive to indigenous, non-western communities across the world. Further still, the language of mental disease has fostered the impression that problems with living and diverse ways of experiencing one's 'life-world' are really pathological behaviours, which have biological substrates, and which can be treated with psychiatric drugs. That is, the progressive iteration of orthodox psychiatry is leading to an over-diagnosis and over-medicalization of forms of behavior which have always been perceived as part of normal human variation within and across cultural spaces. It is increasingly clear that the processes that determine what becomes classified as a 'mental disorder' and what is spared that label are deeply political, driven by hidden economic considerations that are embedded in the global industrial complex. It is also increasingly clear that not only is 'talk therapy' inadequate in meeting the mental healthcare needs of indigenous people around the world, but that the notion of mental illness – far from being resolved or entirely understood – is not monolithic, and needs to be critically assessed from different perspectives and worldviews. The idea that mental illness is an objective referent, which is universally verifiable by all observers regardless of time, context and disposition and widespread obliviousness to its social constructedness, has helped engineer the subjectivities of people across the world – who, like a self-fulfilling prophecy, manifest these abnormalities under the guidance of an idealized psychotherapist. In other words, the conventional biopsychosocial paradigm of mental illness is riddled with paradoxes and problems that can only be addressed by engaging different paradigms. Hence there is a need to employ qualitative, discovery-oriented methodologies and phenomenological studies – which are inductive and designed for the exploration of meaning and experiences (as opposed to hypothesis-testing methodologies) – to discern alternative paradigms of mental illness and wellbeing. In this study, the researcher shifted focus from addressing issues related to mental illness to the paradigm that created it to the first place.

Using a semi-structured interview and Smith and Osborn's interpretative phenomenological analysis (IPA), this study investigated the subjective experiences and meanings attached to the phenomena of mental illness, intervention, and recovery. Six experienced Yoruba traditional healers, with specializations in treating 'mental illnesses' were identified via purposive sampling and snowballing techniques, and interviewed. Open-ended interview questioning was guided by non-prescriptive themes, which the researcher has beforehand prepared to give some directionality to the interviews – while allowing for freewheeling conversations to take place. All interviews were tape recorded, translated from Yoruba to English by independent co-researchers, and transcribed as fully and accurately as possible. The data was analyzed using IPA thematic coding modalities, which began with the researcher immersing himself in the data many times, making unrestricted initial notes and observations on the left margin of the case transcripts, identifying categories in form of analytic phrases from those clustered notes to form subordinate themes, and then forming superordinate themes from the subordinate themes. The transcripts were therefore analyzed and compared across participants to identify perspectival themes that characterize the nature of mental illness, the origin and emergence of mental illness, the procedures for detecting problems, diagnostic dynamics, classificatory frameworks for organizing knowledge of mental illness, treatment procedures and techniques, participants' experiences with healing, and the incommensurability of Euro-American paradigms of mental healthcare to indigenous

wellbeing. Nine superordinate themes were constructed. These were [A] Healing practice is non-formal, plural and inherited, [B] Intervention as interaction with invisible realms, [C] Understanding and classifications of mental illness in narratives of the particular, [D] Healer identity and multiple competencies, [E] The notion of *Ayé*, [F] Mental illness and recovery as injustice and justice restored, [G] Mental illness as shame, [H] Origins of mental illness, and [I] Therapeutic relationship, intervention and recovery: dynamics. These findings indicate that mental illness is a culture-bound, 'local' phenomenon. The interpretations of the researcher further elucidate the inadequacies of the orthodox paradigm of mental healthcare, which rejects the influence of invisible forces (*Ayé* in Yoruba conception) on mental wellbeing. The notion of mental illness and practice of healing, from the perspectives of the participants, is narrative-based, fluid, and strongly linked with restorative justice. The themes generated from participants' stories were ultimately linked to relevant literature. Recommendations from this study included the non-integration of traditional healing practices into conventional healthcare systems, the creation of unorthodox, non-formal platforms of mental healthcare on which indigenous healing practices can flourish, as well as the continued qualitative exploration of other traditional health practices.

CHAPTER ONE

INTRODUCTION

1.1 Background to the Study

The inadequacy of mental healthcare delivery services in Nigeria has been a perennial issue of controversy since the establishment of the pioneer psychiatric hospitals in the federation. With a total of not more than four functional psychiatric hospitals servicing a nation of more than a hundred and fifty million people, Nigeria stands at the proverbial crossroads in charting new directions for mental healthcare delivery for its needful citizens.

Unfortunately, it seems, national conversations about how to remedy the problematic situation have often focused on the supposed need to create more Western-type facilities, articulate new policies that allocate more funding to the ubiquitous promotion of 'mental health', or establish more resilient clinical training programs at universities. These 'solutions' tend to perpetuate the 'business-as-usual' approach to mental healthcare service, which hides a deeper, more compelling, disturbance at more 'fundamental' levels of abstraction. Indeed, through different perspectival lenses, one might conclude that the lack of mental health provisions of the Western type is a hidden blessing – as well as a screaming opportunity for a generic re-evaluation of the notion of mental illness and how to approach new landscapes of wellbeing.

This study derives largely from such an orientation – reflecting a willingness to contest the status quo of health delivery and mainstream clinical praxis in Nigeria. The real issues to contend with are the pretensions to universality evinced by mainstream clinical theory and praxis – which are actually Eurocentric conceptions of mental health – and the 'fact' that there are competing accounts of mental illness and therapeutic engagement that are probably more efficacious in producing situated results than their modern counterpart. These indigenous practices have existed prior to the advent of today's mainstream predilections – and have nurtured rich insights about human behaviour and what might – for simplicity sake – be called 'deviance'.

Historically, the idea of mental illness has been one controlled by Western discourse – while other perspectives and rich traditions involving maintaining wellbeing have been relegated to

the background of irrelevance. This delegitimization of non-Western accounts of mental health and illness betrays a fondness for the assumed superiority of Western knowledge systems. However, there is a growing appreciation of the deep pluralism that underlies mental wellbeing – hence the need to revisit our colonized landscapes by revitalizing these mythopoeic traditions of mental health and stripping Western cosmologies of their homogenous influence over psychotherapeutic discourse. There are indeed alternative aetiologies, alternative efficacies, alternative practices and techniques, alternative intervention strategies and alternative consciousnesses about the 'idea' of mental wellbeing and distress. Perhaps in the promotion of this diversity of alternatives, though presently silenced by the legitimacy of 'science so-called', the Nigerian mental care system might find new directions.

Informing this study is a critique of Western civilization, its pretensions to universal acceptability, the imposition of a singular epistemology that claims multi-spatial validity, the marginalization of indigenous systems of knowledge, the historical colonization and subjugation of indigenous livelihoods and, most especially, the unfortunate perpetuation and representation of the social sciences (Ake, 1979) as a neutral, apolitical enterprise dedicated to the innocent discovery of universal laws that govern behaviour and social contexts.

The focus of this study is ultimately that very important province of Western social sciences, clinical psychology. The researcher seeks primarily to explore a set of circumstances based on the postmodern critique and, chiefly, the indigenous resistance of Western models of psychotherapeutic praxis. Taking in mind the political 'nature' of psychology, as espoused by critical theory and post-colonial discourse, as well as the new trajectories of research towards the reclamation and restoration of indigenous cultures, this study is designed with the motivation to strengthen local traditions in resistance of the hegemony of Western ethnopsychology and therapeutic traditions – *the dominance of the mental clinic*, and help co-create polyvocal contexts of healing that nurture now subjugated communities.

1.2 Statement of Problem

This study problematizes the monoculture of mainstream mental health service delivery in non-Western contexts, which has historically marginalized alternative conceptions of mental wellbeing due to its hegemonic claim to universal legitimacy. This singular controlling

influence over competing meta-narratives of mental health has helped silence/delegitimize the rich practices of indigenous mental health practitioners, therefore impoverishing perspectival appreciation of the construct of mental illness and stifling access to plural frameworks of healing. The problem of the monoculture of Eurocentric psychotherapies in non-Eurocentric contexts is further complicated by the severely limited provision of facilities dedicated to the 'treatment' of mental illness. Bolstered by the resurgence of a critical tradition in clinical psychology praxis, there is a need to stimulate new evaluations of the construct of mental wellbeing and illness along plural, mythopoeic-cultural lines (Akinyela, 2002), and thus enable the emergence of multiple healing cosmologies and practices. The critical emergence of plural frameworks of healing will enable new cultural solutions to mental health service delivery that do not depend on any single framework.

It might be helpful to put this foreshadowed problem in context: with regard to the dominance of Western/mainstream mental health services, it is noteworthy to consider that clinical psychological research and practice today is undergoing a crisis of legitimacy in non-western contexts (as well as in the West). This may be partly due to the increasing popularity of postmodern critiques and the growing strength of non-mainstream critical psychology discourse as well as indigenous disenchantment with Western therapeutic paradigms evinced by the escalating number of narratives of dissatisfaction with, and the number of persons turning away from, traditional (that is, formal) mental health services. Recent studies show that African Americans, for instance, are less likely to visit mainstream psychotherapeutic centres in order to alleviate their distress, and are more likely to visit a local pastor or a trusted elder in their community (Yeh, Hunter, Madan-Bahel, Chiang, & Arora, 2004; Constantine, Myers, Kindaichi, & Moore, 2004; Constantine, Wilton, Gainor, & Lewis, 2002).

The disenchantment from Western articulations of mental health aside, a most influential discussion is unravelling psychology and the critical subset of clinical psychology as culture-bound practices that evolved under a special set of circumstances unique to Euro-America's industrialist history and, by extension, alien to non-western contexts. Louw (2002) especially articulates this critical consciousness as a derivative of the situating of psychology in its historical heartlands and a reflection on its problematic influences on non-western subjectivities. As a consequence, psychology is progressively being seen, not in its hitherto positivistic light as a discipline that could decipher the very laws of human behaviour and mental health and illness, but as a political treatise with deeply Eurocentric assumptions

about ‘reality’ (for instance, the rationalist mechanistic worldview that sees the self as individualistic and embodied in separation from the other) that has the potential (and actually attempts) to subdue other social constructions or indigenous perspectives of wellbeing under a globalist banner of uniformity.

Even more disturbing, and as Louw (2002) points out, is the ‘fact’ that psychology must be seen as a culturally reflexive praxis that shapes and is shaped by its subject matter; in a sense then, psychological praxis creates its subject matter and then studies it. Thus, the historical advent of clinical psychology into non-western communities introduced the social engineering, culture-altering and subjectivity-shaping apparatus of the discipline to indigenous groups. The very presence of new exotic forms of mental distress reported by persons in non-western societies undergoing ‘development’ and industrialization – health issues that were once absent prior to the colonial moment – is an indication that the embrace of Eurocentric psychology (to the detriment of local enunciations of wellbeing), the consequent damaging of deeply held concepts of self, the changing landscapes and burgeoning outlines of cities where sustainable political collectivities once thrived, and the reformulation of livelihoods along capitalist/consumerist lines have done more to wound our ‘spirits’ than to heal us (Alvares, 2011; Botella, 1998; Louw, 2002; Naidoo, 1996; Waldron, 2010). Paradoxically, the historical drive by the Nigerian government, for instance, to build new mental health centres to service the mental healthcare needs of Nigerians is revisited as the further marginalization and delegitimizing of Afrocentric traditions of wellbeing – the perpetual destruction of local sensibilities and ways of life.

The thrust of this postmodern revaluation of psychology is the rejection of the one-size-fits-all approach to mental health or phenomenological universalism; in other words, the politics of the Western therapy room does not agree with the worldview of non-western persons. This incommensurability of Western psychotherapy to the worldviews, lived spaces, life expectations and value systems of, say, Africans is thus one of the chief reasons why many advocates of indigenous decolonization, through seminars, papers and other publications chiefly from the Global South, are insisting upon the description of ‘psychology’ as ‘Western ethnopsychology’, the dismantling of research methods that subtly carry on the colonial project of the West, the development of culturally appropriate research methods consistent with the goals of indigenous groups, the revisiting of the curricula for training of indigenous psychologists in learning contexts, the exploration of marginalized methods of inquiry, the exploration of the disturbing effects of psychotherapeutic research and practice on indigenous

identity, and the amplification of the limitations of Eurocentric psychology and the insidious capitalist-driven politics behind the publication of the Eurocentric nosologies (Aina, 2004; Waldron, 2010; Zacharias, 2006). By representing the hegemonic practice and teaching of Eurocentric clinical psychology as the perpetuation of the power inequities and imbalances between Western and non-Western epistemologies, indigenous researchers employ transgressive research methods and paradigms that serve their decolonization agendas of co-creating local projects of cultural reclamation and revitalization.

I contend that the hegemony of generically Eurocentric therapeutic tradition perpetuates a social injustice by denying other discourses on wellbeing their legitimacy, and maintaining structures that secure a pyramidal supremacy over contending alternatives. This marginalization of indigenous traditions has, fortunately, not gone unnoticed (Naidoo, 1996; Nwoko, 2009; Waldron, 2010).

There is therefore a need to account for the disturbing influences of Eurocentric therapies on indigenous peoples and to investigate how the colonial moment continues in more sinister forms today (cultural and academic imperialism), which is evinced by the dismantling of cultural heritages, the demonization of cherished identities, the breaking and reconstitution of sensibilities along lines friendly to individualistic-mechanistic notions of reality, and the perpetual silence of indigenous practices now delegitimized by academic communities and an expert base. There is a need to develop research modalities that are consistent with local worldviews, which allow indigenous collectivities to tell their stories in their own voices, and which transgress the research methodologies developed in the West that have hitherto not served the needs of indigenous peoples, and have only exploited their narratives for the sake of statistical accuracy or the publish-or-perish syndrome. These are all supportive of the overriding quest for indigenous peoples to tell their stories in resistance of their colonizing Others, and to decolonize themselves from the centrality of Eurocentric conceptions of mental wellbeing – leading to the revitalization of their therapeutic cultures and truly appropriate services to indigenous people now caught in between the legitimacy of the status quo and the unmentionableness of their preferred healing spaces.

1.3 Objectives of the Study

The overarching aim of this study is to address the hegemonic influences of the monoculture of Eurocentric psychotherapeutic traditions on indigenous subjectivities. By observing a specific indigenous healing context and its practitioners, I hope to generate rich themes and descriptions that describe the 'phenomenon' of the indigenous practitioners' perspectives about the aetiology of mental illness that influence their practice, their techniques of intervention, their views of what is healing and the interventions they provide to patients, as well as what they deem to be 'successful' intervention. Among other considerations, the objective is to 'discover' an alternative paradigm of intervention in addressing the problems of mental illness in Africa.

In this proposed qualitative study, I will employ an interpretative phenomenological research design to generate deep narrative/descriptive accounts about mental health from a non-Western context – specifically the Yoruba traditional mental health practitioners and their clients in Ado Odo Local Government in Ògun State, South West Nigeria.

In brief points, the generic objectives of this study are to:

1) Perform a phenomenological investigation of a select number of indigenous traditional healers to describe variants of Yoruba epistemology, ontology, belief systems, practitioner-based techniques, aetiologies and local approaches to mental health and mental distress.
2) Employ narrative methods such as unstructured in-depth interviews/life histories, observational tools, and the collection of site artefacts to investigate the experiences and subjective accounts of the clients/former clients of these traditional healers in a bid to understand their grounded perspectives about influence and efficacy of indigenous therapies – as well as the commensurability of Western mental health systems to local livelihoods.
3) Employ the convenience of video and pictures to create a mural that will complement the text in the 'final' report, and employ non-academic means of knowledge dissemination to help revitalize these traditions in community of concern – thus providing alternatives in healthcare for communities marginalized by the hegemony of Eurocentric psychotherapy

1.4 Research Questions

Qualitative research is generally iterative, inductive, fluid and emergent – unlike quantitative research which tests theories by framing representative hypotheses and then employing statistical analyses to study differences between classes of a population. Therefore the use of hypotheses is not appropriate to qualitative research, because it does involve testing predetermined conjectural statements but is mostly given to the exploration of narratives, subjective experiences and meaning in context (Creswell, 1994, 1998; Denzin, 2005; Denzin & Lincoln, 1998). Although there are documented ways of employing hypothesis-testing protocols in qualitative research, this study will not test hypotheses due to its explorative, phenomenological objectives.

The research questions in this study emerge from the objectives of the study to describe the indigenous practices of healing in Ado Odo Local Government, Ogun State, Nigeria, in a bid to describe a culturally situated alternative to mainstream psychotherapy, to evaluate depictions of traditional healers in mainstream perceptions, as well as to generate rich 'illness narratives' from indigenous health clients and accounts of their experience under such frameworks. My focus is to help enunciate a deep perspectival pluralism (an anti-monoculture) in shaping the idea of healing. With particular regard to the traditional healers I am interested in understanding the kinds of clinical problems that people bring to them, what they believe are the basis (aetiology) for the emergence of these problems, what they do to effect healing, and their views and perceptions or how they explain the basis for their success (that is, their psychotherapy theories). With regard to the clients, the interest of the study will be to understand their views or perceptions (their own theories) regarding the origin of their problems and the basis for their recovery.

The research questions that this study is concerned with are:

1) What do the traditional healers in Ado Odo Local Government understand the nature of traditional healing to be? b) How do traditional healers perceive and valorise 'normality' and/or wellbeing?

2) How do the traditional mental health practitioners approach mental 'health' and mental 'illnesses'? b) What epistemological, ontological and situational constructs inform their approaches, techniques and evaluations of successful intervention?

3) What kinds of psychological problems do people bring to the attention of traditional healers in Ado Odo Local Government?

4) How do the practitioners explain the basis for the emergence of psychological problems in their clients? b) What techniques, rituals and performances are enacted by traditional healers in the 'treatment' of mental distress or the restoration of distressed persons into society?

5) What are the peculiarities of the setting or context under which the practitioners live and work?

6) How do the traditional practitioners understand and relate to Eurocentric orthodoxies and mainstream psychotherapeutic practices in the aetiology, course and treatment of mental illness?

1.5 Significance of the Study

In an article exploring conceptions of grief among Indigenous Australian communities, Koolmatrie and Williams (2000) stated:

> Indigenous people haven't had their stories heard. We've lived with pain and our shame for so long. To be able to tell our story out in the open is a relief.

They thus affirmed the deep psychic colonization and injustice perpetuated by the hegemony of Eurocentric mental health care and the longing for indigenous liberties away from the spaces of delegitimization and imposed inferiority. Mainstream clinical research, by implication, fails to appropriate the worldviews, epistemologies, embedded assumptions and rich perspectives about wellbeing that are long held by non-Western communities, and instead tries to enforce a singular or universal perspective, a one-size-fits-all ideology which decenters and banishes competing articulations of wellbeing and un-wellness to the fringes of a taboo status.

Well-intentioned researchers aware of the political vagaries that shape the psychotherapy room and the arbitrariness of the therapeutic encounter have often attempted to remedy this inequitable situation by affirming the limited applicability of indigenous praxis to more 'scientific' understandings of distress, and have often pushed for a range of counteractive policies and reconfigurations of the mental health practice that enunciate the integration of

indigenous and 'modern' psychotherapy, the training of clinicians for cultural sensitivity and the continued study of non-Western therapeutic landscapes. The problems with these suggestions are that they hardly succeed in tipping the balance or correcting the hegemonic relationship of Eurocentric to indigenous therapeutic schemes, and, even more worrisomely, the employment of orthodox research methods, which have been largely shaped by Eurocentric assumptions and approaches to knowledge creation, do more to militate against indigenous voices and subdue expression than any other colonial scheme concocted.

As non-Western communities become increasingly integrated into modern livelihoods, and adopt modern prescriptions for shaping livelihoods and 'modern' subjectivities (what with the endemic escalation of mental health problems unique to the modernization / industrialization of lived spaces), there is a terrifying possibility that the ways of life, alternative ideas about mental health, and traditions that have shaped indigenous identities will be lost. Indeed, with the very universalization of the English as global language, non-Westerners are being schooled away from their traditions and thrust into tense spaces where the fragments of their once shared identities are in a losing conflict with personality frameworks carved by the modern marketplace. There is, as a consequence, a frightening possibility that the different ways of constructing personhood and approaching therapy will be lost – altogether silenced by the political correctness of the 'subject' created by Eurocentric psychology.

This study is therefore timely because it directly addresses the marginalization of indigenous voices on mental health and employs research methods consistent with indigenous traditions for expression in order to propose counter-hegemonic measures aimed at the revitalization and reclamation of the said traditions. Its connections to the rich traditions of mental health decolonization, popularized by Professor Lambo in Nigeria and Linda Smith in New Zealand, recommend it as a study worth supporting. By drawing richly from literary sources and the artistic conceptions of the good life, articulated by African storytellers and authors in their published narratives, the study of the indigenous worldviews and approaches to therapy weaves together streams of wisdom and history about being, personhood, relating with others, wellbeing, the colonial moment, deviation and experience – thus opening up new vistas for emergent and participatory enactments of wellbeing.

The study hopes to make a contribution and to add to the dynamic nature of indigenous therapeutic practices outside the bailiwick of mainstream clinical practices. This study,

employing an idiographic interpretative phenomenological analysis [IPA] methodology, hopes to break new ground in searching for meaning where certain practices emerge especially in traditional customs and practices not documented in the formal academic literature. The study will lay a base for future research on the needs of the people living in urban environments in the process of mourning the loss of a loved one.

1.6 Scope of the Study

The scope of a qualitative study may be understood in terms of its limitations and delimitations – that is, in terms of the structural weaknesses unique to its articulation and the boundaries for engagement the researcher himself has set respectively. It is important to note that qualitative studies resist rigid boundaries pre-determined before entering the field, and are thus emergent, fluid and based on the situational constraints and growing understanding of the researcher within his studied contexts.

With regards to the weaknesses, this study is limited by the availability and willingness of traditional healers to participate in research of any sort. This reluctance might be due in part to their forced isolation and the general suspicion by members of their increasingly modern society toward them. I believe there are also reasons why traditional healers might perceive academics and researchers as exploitative (Constantine, Myers, Kindaichi, & Moore, 2004).

There are also a number of boundaries I will be imposing on the emergent research, some of which include a restriction to an area not too distant from modern clinical facilities in my study of the narratives of their clientele, a restriction on my participation in traditional enactments of therapeutic processes, and my preference for rich descriptive reports in the stead of statistical analyses. As part of my decolonization ethos, I will not be emphasizing statistical data. There will be some descriptive statistics employed in analysing demographics and demonstrating the nature and source of possible variation in perception of aetiology among participants, and the differences in ranking of some of the problems and themes highlighted by the participants. However, the emphasis remains the qualitative analysis of findings, including the use of murals to capture the peculiarities of the setting or the context of the indigenous psychotherapeutic practice.

CHAPTER TWO

REVIEW OF RELATED LITERATURE

2.1 Introduction

The primary aim of this study is to explore Yoruba traditional healers' experiences and meanings of mental illness, recovery and intervention. The research is based upon the need to address the monoculture of mental healthcare by exploring alternatives to mainstream psychotherapy. The following chapter serves to conceptualise the problems around the hegemonic construct of mental illness – and draws from extant literature and related studies to provide a theoretical context for the construct and its perception in different indigenous contexts. In order to parenthesize the claims to universality assumed by Western mental health institutions, this chapter shall trace the development of the notion of mental illness by examining its Eurocentric origins, probing its hegemonic impact in non-western contexts, studying the pioneering attempts by Professor T. A. Lambo to situate understanding of psychoses within a cultural framework, and illustrating related studies that have attempted to elucidate emic perspectives and champion alternatives to the mental illness paradigm. The thrust of this chapter, being part of an interpretative phenomenological analysis, is not to provide a monolithic theory-base from which falsifiable statements can be drawn and tested as true or not true; instead, the aim is to provide a literary framework that informs the study, and connects the motivations of the researcher to a history of similar studies.

2.2 Lambo: The Role of Cultural Factors in Mental Illness

Lambo (1955), a pioneer in African psychiatry, published an article in the then Journal of Mental Science, which adduced a perspective about mental illness that shaped the course of ethnopsychotherapeutic research in the years that followed. Called 'The role of cultural factors in paranoid psychosis among the Yoruba tribe', the article examined the idea that mental disorders were a cultural phenomenon – and not a universal referent as popularly thought. Lambo (1955, p.239) sought to draw direct links between cultural processes and psychopathology by first presenting human be-ing as a cultural dynamic:

> It is certainly noteworthy that, during the last few decades, whatever the contributory forces, more and more emphasis is being placed on the contention that man is a social being and that his individuality as a person is meaningful only in terms of his relations with others.

Following this postulation of 'man as relationship', Lambo's ensuing preoccupation was designed to question the idea that psychopathology was 'objective' – in the sense of being universally valid regardless of context, culture or class. Aware of the Eurocentric bias and machinations of his discipline, which must have been particularly glaring in his time, Lambo (1955) was notably articulate in rebuking Carothers (1947), who pathologized the African race by arguing that 'the peculiarities of primitive African mentality might also be seen as a failure of development or lack of function of the cortex in general, an approach which would accord with Vint's observation that the cortex of the native brain was found to be narrower than that of the European' – thus highlighting the deeply prejudiced origins of psychological disciplinarity. Lambo (1955) referred to these obviously 'prejudiced observations' about the African in the context of fixing what occurred to him to be the great problem of psychiatry: the elucidation of mental illness as a cultural dynamic, over and against its reductionistic relegation to the physical states of the brain.

Lambo asserted that there is converging evidence to support the notion that man is a 'social being' conditioned by cultural pressures. He suggests that it was becoming important to understand behaviour and mental health only within a cultural framework, and insisted that 'attempts should be made to discover how closely related are observable personality traits and analysable cultural phenomena' (Lambo, 1955, p.239). He stated that 'cultural anthropologists and those psychiatrists who had been fortunate in working among peoples of different cultural institutions have laid down the hypothesis that cultural factors influence the aetiology and psychopathology of mental disorder' (1955, p.240), and sought to concretize these findings in his lifetime work by creatively exploring psychopathology within culture-bound constraints.

Lambo was very concerned about the question of 'fit' and the appropriateness of Eurocentric paradigms and nosologies for Africans or non-Western persons. He stated that '…one is forced to the conclusion that there are real qualitative differences in the psychotic reactions of individuals with different cultural and racial backgrounds – differences which make it impossible to fit them into the accepted nosological framework' (Lambo, 1955, p.240). Thus, by seeking to distinguish the African 'person', and separate his functioning from the

conditioning perspectives of an imperialistic viewpoint, Lambo showed how clinical research interfaces with political discourse – a critical coupling that has inspired the emergence of modern Afrocentric critical discourse. His suggestion that 'objectivity can sometimes become an obstacle in the search for truth' (Lambo, 1955) is a critical appraisal of our modern preoccupation with paradigms of statistical coherence at the expense of situated understanding. In other words, Lambo's work and postulations, his critique of epiphenomenalism (the idea that mental processes are merely emergent properties of universal brain states) and psychotherapeutic universality might be justifiably read as an invitation to an understanding of psychopathology as a cultural construct, and an invitation to explore qualitative, culturally appropriate ways of researching into the phenomenon of mental disorder.

Speaking of the celebrated late Professor Thomas Adeoye Lambo, a pioneer psychiatrist whose Afrocentric cultural approach to understanding the phenomenon of mental illness serves as a foundation and motivation for this study, Erinosho (2007, p.5) states the following:

> Professor Lambo theorized about normal and abnormal human behaviour and was ahead of his time in many respects. His 1955 MD thesis at Birmingham provided the clue to his dexterity as a theorist. It is in the context of this landmark study on paranoid psychoses among the Yoruba that he propounded his theory of abnormal behavior that transcends African societies. He was able to demonstrate that paranoid psychoses in…Africans is qualitatively different from what he observed among Europeans. The thesis shows the remarkable insight of Professor Lambo and his knowledge of philosophy, sociology, social anthropology, and psychology. One still marvels at the end of reading the thesis today whether Professor Lambo trained as a philosopher, psychiatrist, sociologist, psychologist, and social anthropologist because the thesis underscores an interdisciplinary focus.

Consequently, Lambo's bold postulations about mental illness laid the foundation for future explorations away from the Eurocentric constraints of 'mental illness' and towards the promise of culturally appropriate definitions and understandings of the phenomenon.

2.3 The Concept of Mental Illness

The limitlessly varied manifestations of human behaviour have fascinated scientists and philosophers alike for a long time. It probably is safe to assume that what may be termed 'problems' of behaviour or internal human life have always been part of human experience.

However, there are strong reasons that suggest that the concept of mental illness is a relatively recent phenomenon. Bracken and Thomas (2001, p.724) affirm this by saying:

> Both critics and supporters of psychiatry agree that, historically, modern psychiatry is very much a product of the European Enlightenment. Prior to the Enlightenment, or the Age of Reason as it is also called, the concept of mental illness as a separate area of medical endeavour simply did not exist: there were no psychiatrists or psychiatric patients as such. It is only with the intellectual and cultural developments of the age of reason that we see a field of medical work open up which eventually becomes psychiatry.

The 'Age of Reason' was a movement in Europe that advocated the use of 'reason' and individualism as central cultural values. The time period in which this movement was most prominent was between 1650 and 1800. Bracken and Thomas (2001, p.725) however assert that

> The age of reason is difficult to define and to locate historically. However, beginning in the mid-17th century it is clear that there was a major shift in the cultures of Europe. It is impossible to say exactly why the Enlightenment began and why it developed as it did. Some historians argue that it began with the rise of science, others with the rise of capitalism. Other factors were the emerging bureaucracy in most European states and the fact of colonialism and increasing literacy. However, these influences weren't unidirectional, the assumptions which were at stake in the Enlightenment also fed into these developments. Enlightenment meant a turn towards the light: the light of reason. There was a turn away from a focus on religious revelation and the wisdom of the ancient world and towards science and rationality as the path towards truth and progress. On a practical level, with its focus on reason and order, the Enlightenment spawned an era in which society sought to rid itself of all 'unreasonable' elements.

Porter (1987, p.14-15), speaking about the circumstances surrounding this banishment of the 'unreasonable', noted that the enterprise of the age of reason, gaining authority from the mid-seventeenth century onwards, was to criticize, condemn and crush whatever its protagonists considered to be foolish or unreasonable. 'All beliefs and practices which appeared ignorant, primitive, childish or useless came to be readily dismissed as idiotic or insane, evidently the products of stupid thought-processes, or delusion and daydream. And all that was so labelled could be deemed inimical to society or the state - indeed could be regarded as a menace to the proper workings of an orderly, efficient, progressive, rational society'. Evidently, as Foucault (1967) himself noted, the rise of the institution of mental illness and the practices surrounding it were deeply connected to the political interests, social exclusionary proclivities, and

increasingly rationalized or mechanized ways of life. Bracken and Thomas (2001; p.725) comment:

> [Foucault] coined the term 'The Great Confinement'. Furthermore, he argued that it was only when [unreasonable] people had been both excluded and brought together that they became subject to the 'gaze' of medicine. According to Foucault, Porter and other historians, doctors were originally involved in these institutions in order to treat physical illness and to offer moral guidance. They were not there as experts in disorders of the mind. As time went on, the medical profession came to dominate in these institutions and doctors began to order and classify the inmates in more systematic ways… Medical superintendents of asylums gradually became psychiatrists, but they did not start out as such. Alongside the dominance of psychiatrists, the concept of mental illness became accepted. *In other words, in this account, the profession of psychiatry and its associated technologies of diagnosis and treatment only became possible in the institutional arena opened up by an original act of social rejection* (italics mine).

This account of the evolution of the concept of mental illness firmly situates it in the dynamic processes of the Enlightenment Era. The cultural imperative to resist a blasphemous history of superstitious rituals and religious-motivated behaviour and thought inevitably spurned institutions that were designed to support the framework that was being developed. Ironically, the institutions that were designed to keep the 'unreasonable' away, by that very act of desperate exclusion, invented the very reality of mental illness (Bracken & Thomas, 2001; Porter, 1987).

Consequently, the concept of mental illness is deeply situated in Eurocentric concerns, and evolved from historical epochs that necessitated the reification of the rational self – as opposed to the 'irrational' one.

Consequently, in the loss of social width, a quest for rational depth began, and was borne out in attempts to arrive at fundamental explanations for the whole as the sum of its parts. This reductionist enterprise and logic was in keeping with the motivations and zeitgeist of the time. As expected, the infinitesimal array of legitimate (allowed) human behaviours began to shrink considerably (Bracken & Thomas, 2001). The modern evolution of the DSM (Diagnostic and Statistical Manual for Mental Disorders) nosology helped concretize the concept of mental illness. Subsequent iterations and editions of the manual have increasingly reduced the province of 'sanity' by continuing to describe new behaviours as pathological – thus betraying the same logic and perpetuating the same conditioning as its epochal origins. In this sense, the DSM nosology is a manifesto of the 'Great Confinement' (Foucault, 1967).

Kutchins and Kirk (1999, p.11) assert then that the 'DSM is a guidebook that tells us how we should think about manifestations of sadness and anxiety, sexual activities, alcohol and substance abuse, and many other behaviours. Consequently, the categories created for DSM reorient our thinking about important social matters and affect our social institutions'.

2.3.1 Eurocentrism in Psychotherapeutic Practice

It is thus possible to read the emergence of the concept of mental illness as the advent of an increasingly rationalized society. It would seem that the notion of psychopathology understood within the holding discipline of psychology is intimately connected with its Eurocentric historicity – such that one cannot begin to understand psychopathology unless one understands the conditions that invented it. Naidoo (1996, p.2) opines that

> Psychology has traditionally been Eurocentric; i.e, it derives from a White middle-class value system. As a result mainstream psychology has largely been ethnocentric in its orientation, training and application and has neglected the mental health concerns of other racial groups and the socio-political injustices they endure on a daily basis.

Psychology is usually presented to students and taught as the scientific study of universal laws of behaviour and processes. As a result, there is the unstated assumption that psychology and its applied sub-disciplines are non-aligned tools with which we can access culture-neutral information about human behaviour and or behavioural problems. Culture is often presented as an extraneous variable, where the dependent variable is behaviour; the implication is that culture is not central to human experience, and that mental illness or any form of behaviour is not culturally mediated, and has a universal substrate (physical or psychological).

It was this assumption of neutrality that permitted the hierarchical categorization of Africans as 'primitive peoples' – with explanations for their primitiveness centred on the size of their cortex or their ways of conceptualizing the world. The African was usually accused of possessing a 'pre-logical type of mentality' (Lambo, 1955). Lambo (1955, p.246) elaborates on this:

> In Yoruba culture, for example, if a man finds the hair or a nail belonging to, or even a piece of material which has been worn by, an enemy, he believes he has only to "use" them in order to bring about his enemy's death or to injure him. In this mode of thinking, there may be said to be a magical or mystical denial of the concept of causality and of the reality of their spatial and temporal relations. Lévy-Bruhl, however, omits the fact that "pre-logical

> mentality" occurs in both civilized and primitives, though to the civilized it is, of course, much more in evidence in primitives.

Additionally, Storch (1924), Schmideberg (1930) and Burstin (1935) sought to characterize the 'primitive' man's thinking as analogous to that of the schizophrenic (Lambo, 1955). It was believed that the African had not yet attained a level of cognitive sophistication that gave him the power to establish causal links between objects. The magical consciousness of the 'primitive' was therefore pathologized.

Lambo's argument was to supply evidence that mental illness is culturally defined – and not characterized by a universal substrate as such. His concern with this was to absolve the 'primitive' from blame and from the dehumanizing condescension of an abstract universalism. To do this successfully, to fully liberate the African from the supposedly neutral clutches of linearity, Lambo (1955) went to great lengths to bracket the discipline of psychiatry itself. In the same vein, Naidoo (1996, p.5) sought to make more explicit the Eurocentric undercurrents of psychological practice:

> It so happens that the basic assumption of the dominant psychology is rarely examined or admitted. The reluctance to examine the basic assumptions of dominant psychology derives in part from fears of undermining the discipline's tenuous claims of its status as a science. That this dominant psychology is founded on and permeated with the implicit assumption that the only human reality is first Eurocentric, then middle class, and finally male in substance, represents a disregard that this culture-, class-, and sex-bound perspective is but one in a universe of diverse human realities. The perpetuation of this theory and practice predicated on one world view, one set of assumptions concerning human behaviour, and one set of values concerning mental health restricts our knowledge and understanding, limits our ability to be effective cross-culturally, and reduces the counselling process to a technicist-orientation. It also deprecates the value and usefulness of indigenous modes of intervening.

The assumption of a universality of aetiology, manifestations and intervention – much to the detriment of alternative conceptions and indigenous beliefs about the phenomenon – is therefore tethered to the psychology's Eurocentrism. Hence, the reductionist quest for a 'neutral' referent-element that explains the psychopathological whole is one of the central tenets of modern mental healthcare. The lens of mental care is squarely focused on the reified 'individual', created by a rationalized social order of linearity and exclusion. The problem, it is emphasized again and again, is in the 'individual'.

2.3.2 Culture and Psychopathology

The issue of contention in this study is the phenomenological universalism assumed by the mainstream practice of psychotherapy. It is almost universally presumed that healing, wellbeing and 'illness' – as enunciated by 'Western' theorists and practitioners – is a neutral referent that transcends cultural, perspectival boundaries, that there is only one legitimate appreciation of wellbeing and illness, and that non-Western approaches to valorising these 'phenomena' are 'bells and whistles' – cosmetic accompaniments to illegitimate ways of knowing. This study challenges the orthodoxies of psychotherapy by exploring the situated fringe practices of indigenous healers and their clients – in a bid to articulate 'new' reifications of mental health and illness and, ultimately, to reclaim these practices as legitimate ways of knowing. Concomitantly, this study is heavily influenced by a current of ethnopsychotherapeutic literature on fruitful evaluations of indigenous realities, and the critical discursive re-interpretations of 'reality' (and by implication, psychotherapeutic reality) as multidimensional, polyvocal, ambiguous and culturally embedded.

By reading mental illness as an invention, a Eurocentric reification of the Age of Reason, and an institution designed to colonize, exclude, rationalize and bring behaviour under the aegis of state control, one is afforded an opportunity to 'bracket' the imposed universality of psychopathology, and thus study it from different emic perspectives. The indictment that psychology has failed to fulfil its professional mandate to the culturally different has become endemic (Naidoo, 1996). The status of psychology as a universal discipline is being increasingly contested by practitioners of all races (Katz, 1985) who have appealed to the profession to re-examine and re-evaluate the theory and practice base of psychology and its sub-disciplines. Consequently, more and more psychologists, aware of the paradox of their discipline's origins, and discontented with mainstream psychology, are calling for a theory and practice relevant to their particular sociocultural milieu. They are insisting that psychopathology cannot be understood apart from the cultural contexts that created it; and that if there are no absolute referents for mental illness, it is now imperative to leave behind the posturing of nosologies like the DSM, and fashion new ways of understanding behaviour in a post-psychiatric age..

2.3.3 Related Ethnopsychotherapeutic Studies

The quest to develop 'many psychologies' now defines the disciplinary landscapes – as evidenced by the growing number of research tailored after Lambo's (1955) concern for new descriptions of mental illness. Ethnopsychotherapeutic practices have long been recognized as existing side by side with 'orthodox' therapies (Ovuga, Boardman, & Oluka, 1999). Based on the belief systems of culturally diverse groups, non-Western mental healing traditions have, from the margins, served as a source of alternative healthcare delivery to indigenous people, who are generally suspicious of Western psychotherapy – or are alienated from the service. Unrecognized, many indigenous healing methods, studied by a growing number in the academia unsatisfied with mainstream psychotherapy, continue to serve locals across the globe (Raguram, Venkateswaran, Ramakrishna, & Weiss, 2002; Abbo, 2009; Kabir, Iliyasu, Abubakar, & Aliyu, 2004, Boroffka, 1980; Broadhead & Abas, 1996; El-Islam, 1992; Irigoyen-Rascon, 1989; Jilek-Aall & Jilek, 1993).

For instance, in Zacharias (2006), the effectiveness of Curanderismo, an indigenous therapeutic paradigm that has evolved from the Oaxacanean people of Mexico, is reported to rival that of Western psychotherapy – given the acceptance of orthodox treatment outcomes. The complex nosologies and treatment modalities employed by the Curanderos are reportedly enriched and informed by a holistic inclusion of a spiritual dimension in their mental health and illness scheme – a concept largely missing in most Western psychotherapeutic practices.

The Igbo of Eastern Nigeria also have an elaborate cosmology that implicates healing and illness, deviance and wellbeing. Nwoko (2009) states that 'in Igbo perception, every ailment comprised the invisible, spiritual or supernatural origin and visible or natural origins. Hence they commonly perceived ailments especially the protracted ones like insanity as dual rooted.' Consequently, the Igbo therapeutic system accommodates various classifications of healers called Dibia, who possess skill bases that define the healer's role as a mediator between the spiritual and the physical realms. Similarly, Yoruba healers (babaláwo) play the role of diviners, and often employ water-themed rituals to confront spirits and gods, who are often viewed as the primal causes of deviance or madness (Rinne, 2001; Adegoke, 2008; Agara, Makanjuola, & Morakinyo, 2008).

Various other indigenous therapeutic systems subsist across the globe – existing alongside Western psychotherapy. These frameworks are often irreducibly different from Western conceptions of normality and abnormality. Waldron (2010) states:

> ‘The notion that physical and mental illness are conceptualised and experienced similarly throughout the world is one of the many erroneous assumptions made about culturally diverse peoples around the world by some health practitioners working within Western medicine and psychiatry. Every society embraces particular ‘cultural theories’ or ideologies that set the parameters within which normal, abnormal and deviant behaviour is defined. These cultural theories on illness, treatment/healing and health often stem from diverse observations, understandings and interpretations of specific symptoms, the behaviour of persons affected by illness and how symptoms are uniquely experienced and explained in specific cultures’ (p.50).

The unique descriptions and narratives diverse communities construct around their varying conceptions of healing and deviance define their approach to indigenous therapy. These systems of traditional healing are sacred and vital to the communities that uphold them – because it represents their beliefs, values, and their constructed identities. For instance, the care provided by the local Oaxacanean healers, the curanderos, ‘often represents the sole health resource that is reliably accessible to the general public’ (Zacharias, 2006). Thus, these healing traditions, their actuating cosmologies, and their active agents, are a vital aspect of the lives of the communities they are constructed to serve. However, the existence and perpetuation of traditional therapeutic contexts is threatened by the hegemonic status of classical psychotherapy. Zacharias (2006) states that ‘the clearly significant care provided by curanderos is rarely acknowledged by the hegemonic system of Western medicine. For example, Mexican law recognises the practice of curanderos as culturally important, but not medically valid.’ Additionally, Zacharias (2006) adds: ‘The dominant attitude in public discourse concerning the symbolic aspects of Curanderismo has been one of rejection. This continues to be the case due to the growing influence of biomedicine in Mexico. In regard to Mexican medical policy, this lack of recognition has led to a situation where this important medical resource remains underestimated and underresearched.’ The ‘underground’ status of Curanderismo is similarly suffered by other traditional healing practices in culturally diverse groups due to the Westernization of ideas on mental health and illness. The hegemonic framework of Western psychotherapy casts diverse understandings of mental health in subordinate positions, hence creating a hierarchy of knowledge by which indigenous frameworks are evaluated and delegitimized.

2.3.4 The Hegemonic Influence of Psychopathology

Today, classical clinical practice is recognized as standard, universal in its applications, and commonsensical enough to be viewed and understood by anyone who exercises correct thinking. The not-so-obvious implications of the universalist claims of Western psychotherapy is that other systems, other cosmological matrixes, other narratives about human be-ing, other conceptualizations of history, and other perspectives on the essentially contested ideas of normalcy and abnormality, are illegitimate deviations from real knowledge. A pyramidal structure of knowledge about human wellness is thus sustained, situating Western-oriented explanations of the human person and society at the tip, and other frameworks at the graded bottom – depending on their proximity to the 'truth' of Western therapy. Waldron (2010, p.51) addresses this power inequity by affirming that 'it is Western scientific traditions, epistemologies and practices that often dominate within the social structures of Western and non-Western societies, resulting not only in the normalization and privileging of these traditions, epistemologies and practices, but also the pathologizing of non-Western ideologies and practices.'

This dichotomy of knowledge systems translates to less than equitable circumstances for indigenous persons around the globe and their age-old cultures and perspectives about therapy – a situation characterized by denial of access to other forms of therapy, an erosion of cultural identities and value systems, an establishment of passive reception of 'meaningless' narratives, and the destruction of social ties of kinship and other functional bonds critical to livelihood. Other insidious features of marginalization are the oppressive imposition of a social space and the forced internalization of new values. It might be helpful to understand the dangers of psychotherapeutic colonization with some examples employing two of Western psychotherapy's inter-related sacred tenets, confidentiality and autonomous independence.

Confidentiality describes a tacit and explicit pact between a client and a clinician, in which the clinician is ethically constrained not to disclose information about a client to anyone external to the therapeutic context. A therapeutic alliance, consequent upon clinician-client negotiation of these constraints and values, is necessary in a stylized Western psychotherapeutic context. Though there are perceived limitations to this ethical submission of confidentiality, the notion is rooted in the idea of the human self as an autonomous, independent entity (Wright, Webb, Montu, & Wainikesa, 2002). Consequently, the idea of

confidentiality is being questioned in non-Western contexts because it reifies the self as independent and does not accommodate varying conceptions on the self. Gergen and Gergen (1988) remind us that there are competing views on the self, which is perceived in many non-Western cultures as relationship. Similarly, the therapeutic outcomes of Western psychotherapy idealize the healthy individual as autonomous, independent and rational, whereas, in many other non-Western cultures, the idea of an individual as autonomous and 'rational' is the very description of abnormality. Thus, regarding psychotherapeutic colonization, Stewart (2008, p.12) states that 'counselling Indigenous individuals from a non-Indigenous perspective (i.e., Western perspective) is a form of continued oppression and colonization, as it does not legitimize the Indigenous cultural view of mental health and healing'.

Ultimately, the Western hegemony, itself constructed in a social moment and just as inherently vulnerable as other conceptions, serves to perpetuate crippling stereotypes (Ocholla, 2007) that do a disservice to indigenous worlds. Diverse ways of healing and being that hold promise for new alternatives in psychotherapeutic thought are considered illegitimate and therefore, not very useful. The diagnostic, therapeutic, and nosological systems of Western psychotherapy are thus viewed as the evolving default of mental healing – to the perpetual subordination and oppression of indigenous knowledge systems.

One of the innumerable ways indigenous spaces within the Nigerian context are territorially abused by the claims to power emanating from the so-called western hegemony are by the institutional use of the DSM (Diagnostic and Statistical Manual) in understanding mental discomfort. The Manual prepared by the American Psychological Association is quite popular among the sprinkling few of Nigerian clinical practitioners, and is frequently referred to and enforced as the standard perspective on mental illness. In a nation with largely disenfranchised people, who experience a strong disconnect between their hopes for a better life and prevalent socio-conditions, there are strong feelings of dependence on authority figures and professed experts – especially on persons who have some form of formal education and western professional training.

This situation is easily exploited by clinicians who, in the few functioning centralized mental health centres in the country, dispense diagnoses of mental illnesses and their attendant treatment procedures – all the while failing to acknowledge the narratives that shape indigenous lives.

By devaluing the cultural stories and meaning frameworks constructed by clients, the DSM manual propagates a single story – and its uncritical employment by clinicians in non-western contexts only serves to create more problems than can be handled in traditional ways. The DSM silently insists that there is a singular therapeutic referent, and consequently provides a context which synchronizes client behaviour with symptomatic expectations informed by 'western' ideas of mental illness. Far from being a promoter of mental health in Nigeria, western clinical praxis effectively silences competing paradigms and colonizes indigenous behaviour – successfully constructing only one way to experience life difficulties and, thus, only one way to 'treat' them. The current subjection of Nigeria's rich baritone of cultural plurality to the homogenizing effects of western ideas is even more troublesome when one considers the thrillingly multifarious approaches to wellbeing available in the country. Owing to the neo-colonialist influences of these orthodox ideas on mental health, the Yoruba mythology – which implicates the divine in mental illness and the use of water in alleviation of problems – and the Igbo mythology – which invests upon the Dibia the power to consult other-than-physical forces to come to one's aid as well as the community support that spontaneously assists community members with loss and grief – are cast off as primitive deviations of western philosophies.

The notion that there are meta-narratives (from which indigenous knowledge systems are warped digressions) and the problem of power inequities and imbalance between Western and non-Western systems are really an epistemological issue. That is, at the root of the universalist claims and the globalizing ideals of Western psychotherapy is the problem of knowledge. Duran and Duran (1995; in Stewart, 2008; p.12) state that 'a postcolonial paradigm would accept knowledge from differing cosmologies as valid in their own right, without their having to adhere to a separate cultural body for legitimacy'. Paradigmatic controversies about what can be known, the philosophical nature of knowledge, and the relation of the knower to the known, form the essential matrix of discourse about decolonizing healing. Unfortunately, academic discourse on the philosophical undertones of clinical practice in Nigeria, and how this might liberate new spaces for indigenous practice as well as enrich the 'mainstream' psychotherapeutic institutions, is all but lacking – frowned upon by the orthodoxy of scientific rigour and the fear of relapsing into philosophical 'talk'. The next section briefly confronts the issues and delineates the argument as a clash of modernist and postmodernist ideas about the nature of legitimate knowledge. It is shown that if there are no objective referents by which any observer might claim to have perceived 'truth

as it is', that is, if knowledge is co-constructed and culturally embedded, biased, political, gendered and vulnerable, then the globalizing force of Western clinical orthodoxy and the hierarchical classifications of knowledge systems can give way to more equitable circumstances for the survival of indigenous knowledge systems.

Constantine, Myers, Kindaichi, and Moore (2004) report a startling underutilization of psychotherapeutic facilities among indigenous people in the United States of America. Apparently, there exists a general hesitancy and reluctance exhibited by people of colour in the States to use formal mental health services. Among the reasons espoused for this growing trend are the high cost of traditional health services, the felt urge to locate less stigmatizing forms of therapy and the compelling need to utilize less formal, more indigenous forms of therapy that are life-affirming and nurturing to constructed identities. Concomitantly, Constantine, Myers, Kindaichi, and Moore (2004) state that non-White Americans are reportedly less likely to utilize mainstream therapeutic facilities because they do not see these services meeting their deeply engrained needs. As the case would have it, this reluctance exercised by ethnic minorities is not limited to the United States. Thus, other reports on mental health underuse (Yeh, Hunter, Madan-Bahel, Chiang, & Arora, 2004; Constantine, Wilton, Gainor, & Lewis, 2002; Nwoko, 2009; Washington, 2010; Centre for Addiction and Mental Health, 2009) have shown that culturally diverse groups across the globe are increasingly participating in indigenous therapeutic spaces. Supported by cultural perspectives (such as the largely African view which implicates the spiritual realm in the understanding of behavioural problems) that are incongruent with mainstream psychotherapeutic praxis, a significant section of indigenous people (understood here as non-Western people), reports show, leans heavily on the expertise, influence and meaning of traditional healers, communal worldviews and historically transmitted rituals respectively. This indigenous suspicion of the efficacy of Western psychotherapy is reinforced by indigenous styles of conceptualizing the human person in relation to her world and the meaning of mental illness.

The critical issue I am concerned with is, however, not merely the 'fact' that more non-Westerns are irritated by Western conceptualizations of mental health and the assumptions that empower psychotherapeutic praxis, or the 'fact' that there are other systems of healing and meaning radically different from that espoused in classical psychotherapy. The deep-seated diversity of perspectives about mental wellbeing and distress are well taken for granted, and need not be established here – except in passing to more decisive concerns. The

investigation of indigenous forms of healing is an ongoing project, and the culture-specific resources, owned and sustained by these diverse groups, provide a vibrant source of fascination for investigators. These indigenous forms of healing are culture-sensitive, holistic, spiritual, collectivistic, and rich in variety. For instance, some pastors, clergymen and priests play the role of healers for some in the African American and Latino populations (Constantine, Lewis, Conner, & Sanchez, 2000); Asians sustain close-knit family networks that serve as healing sources in times of distress (Solberg, Ritsma, Davis, Tata, & Jolly, 1994); and, some American Indians engage in elaborate sun-dances and pipe festivals in their quest for a sustained sense of rejuvenation and wellbeing (Garrett & Wilbur, 1999). What is of crucial concern, nonetheless (as exemplified in critical psychology's thrust), is how these other systems fare in the arena of competing ideologies, and how practitioners might apply these concerns in progressive ways. Waldron (2010) states that health systems and perspectives different from Euro-Western paradigms are marginalized and rendered illegitimate by the imperialistic character of the latter. Founded on modernist assumptions and positivistic notions of universality, mainstream clinical praxis depicts all other conceptions of health as naïve, antiquated or substandard. By internalizing Western perspectives, etiologies, nosologies and diagnostic systems as standard, clinical practitioners help reinforce a hierarchy of mental health beliefs and treatments. Assessments, diagnoses and treatments are shaped by Western hegemonic perspectives that are radically at odds with the beliefs and practices of culturally diverse groups, thereby creating a crisis situation for groups not represented by Western claims. In short, the refreshing breath of air that critical psychology brings to the Nigerian mental health situation cannot be over-celebrated. Additionally, by alluding to the political nature of psychotherapy (such as the frailties of diagnosis and assessment), and critiquing what may be called Western therapy's myth of neutrality, it shows how every paradigm (Western and non-Western) is laden with values, locally constructed and spoken to power by interested (as opposed to disinterested and unbiased) groups, historically embedded, and storied – such that to assume one culture's suppositions about human be-ing, mental health and treatment have anything to do with a universally objective referent is to ignore the 'danger of a single story' .

2.3.5 Attempts at Framing Afrocentric Psychotherapies

Now it seems clear that the discourse of mental illness proceeds from an ethnocentric point of view, which ultimately serves to silence alternative worldviews and colonize human experience in ways that are adaptable to the interests of industrial expansion. In this sense, the orthodox practice of alleviating mental illness paradoxically perpetuates it – and even more, it silences competing conceptions about what it means to be human and alive (Akomolafe, 2013), and merely conditions subjectivity (Louw, 2002) to be amenable to the global industrial complex. Eurocentric psychotherapy seems to be designed for the continued mechanization of human *be*-ing.

Oshodi (2004, p.118) states that 'Eurocentric concepts [of mental health] continue to accentuate individuality, independence, materialism, control, competitiveness, and differentiation, which collectively further remove the strengths of natural orderliness and harmony from human functioning. Conversely, Africentric mental health practices and approaches continue to rely on the deep-rooted universal and natural views of personality and healthiness. These include the need for harmony, the need for inter-relatedness, and the need for balance with an orientation toward Ma'at which is the inherent need for orderliness in life'. There have consequently been attempts at drawing from perceived values of the African continent to articulate an organic nosology and approach to mental health – one which does not perpetuate Eurocentric notions of abnormality, and one which appeals to the sensitivities of African people, one which restores African agency (Asante, 2007). Afrocentric psychologists, understanding the hidden dynamics of Eurocentric standards of normality, have strongly suggested the cultivation and practice of Afrocentric-based ethos, values, and behaviours among Blacks. Oshodi (2004, p.125) in his book, 'Back Then and Right Now in the History of Psychology', states that the 'thrust of normality for Blacks revolves around harmony, inclusiveness, collective responsibility, co-operation, interdependence, complementarity, sameness, communality, and above all, spirituality – which are at the core of African-based values and norms.'

It is important to note that the quest to create an African perspective and approach to mental health is not new. Scholastic support for the articulation of Afrocentric psychotherapy came from the likes of Lambo (1978), who affirmed that according to the African phenomena:

- African psychotherapy is rooted in cultural and social norms.

- The practice of psychotherapeutic medicine is effected through the alignment of mind and body.
- The tradition of psychotherapy is directly woven into the whole or center of religion and communal living
- The nature of psychotherapy is positively and collectively characterized by the supernatural, animate, inanimate, unconscious and conscious acts.
- African psychotherapeutic activities, acts or rituals are intertwined with ancestral power, the presence of deities, and the entire spiritual world.
- African psychotherapy utilizes diagnostic and spiritual treatment plans under the direction of sacred, gifted, and trained healers.
- African health psychology is preventative, rehabilitative, symbolic, proactive, and harmonious in nature.

Lambo (1978, p.36) specifically proclaimed that in African modes of psychotherapy, 'everyone takes part in the treatment; the ritual involves the healer, the patient, his family and the community at large. The group rituals – singing and dancing, confessions, trances, storytelling, and the like – that follow are powerful therapeutic measures for the patient. They release tensions and pressures and promote positive mental health by tying all individuals to the larger group'.

Some critical work has gone into crafting psychotherapeutic platforms that incorporate activities that are reflective of the African worldview (Nwoye, 2005) – most notable of which is the articulation of NTU Psychotherapy (Phillips, 1990). NTU, a root word from the Bantu tribe of central Africa, 'represents a force with universal applications to human living. Phillips' NTU therapeutic system contends that humans' mental health is fully enhanced through the inter-locking factors of harmony, balance, interconnectedness, cultural awareness, emotional healthiness, and authentic behaviours. NTU therapy's sole goal is to guide humans, particularly Blacks, wholistically [sic] towards a balanced and harmonious living with oneself and one's environment' (Oshodi, 2004, p.127).

Some other contemporary African-based psychotherapeutic modalities include the Oshodi Empty-Pot Healing Approach [OEPHA] (Oshodi, 1999); Therapeutic Supplication [TS] (Oshodi, 2004), which aims to create in the individual or group a state of fulfilment, balance, and achievement; and, Sand Therapy, which is an African-centered healing approach that is

based on the diagrammatic impressions of the client's needs illustrated by the healer on a pile of sand, which is laid out in a circular frame (Oshodi, 2004).

The field of African-based alternatives is surprisingly not sparse as one may be led to think. Like those modalities mentioned above, there have been organic, visceral, 'fleshy', 'carnal', 'feminine' and incredibly diverse Afrocentric approaches to the idea of mental health for years – though often hidden under the monolithic dominance of Eurocentric ideals about normality, abnormality, rationalized consciousness, and untamed consciousness. Some of these Afrocentric psychotherapeutic technologies (Oshodi, 2004) include:

1) **Water Therapy**: Different from the Eurocentric hydrotherapy, water therapy is a projective modality (like Sand Therapy) that involves the healer or therapist intensely gazing into a basin of water as the client verbalizes his or her issues. By methodically gazing at the water, the clients' problems are presumed to be visualized. Therapeutic breakthrough occurs if the therapist has a good understanding of the dynamics of spirit.
2) **Stool-Hand Approach Therapy** (SHAT): This modality is deeply embedded in African traditional healing arts, and involves the symbolic nature of stools in African traditions. Oshodi (2004, p.135) says that 'within the context of Africa, the stool (i.e. a seat), especially the golden type, is a sacred tool that commands the power of spirituality, respectability, protection and power.' In this therapeutic modality, the therapist is required to place an easily moveable stool towards the client. The client is required to place both hands on the stool at which time he or she is also required to actively listen as the therapist verbalizes all the characteristics and ingredients of the stool. The therapist then verbalizes to the client that he or she becomes symbolically cleansed, and the hands placed on the stool become instruments of psychological strengths against future troubles.
3) **African Recreation Therapy**: This therapeutic modality is articulated on the recreational activities of Africans. It is theorized that the longstanding practices of recreation such as 'storytelling', 'laughing talk', 'proverbial talk' and 'old talk' are therapeutic. This therapeutic modality is group-based and relational. It involves proverb-sharing, laughing, and thoughtful reflection on one's activities. These unstructured, flexible and 'natural' activities contrast sharply with mainstream clinical settings.

4) **Cry Therapy**: Based on the Afrocentric longing to release emotional energies, cry therapy theorizes that humans undergo relief through emotional signals and tears. The therapist's task is not only to allow the client to shed free-flowing tears, but also to guide him/her into corrective solutions to identified problems.

Honourable mention is made of Ebigbo's (1995; 1997) 'Harmony Restoration Therapy', which is articulated on the idea that the African is a composite of different dimensions of being, and it is the harmony between these spiritual, psychosocial and physical elements that creates wellbeing.

It is abundantly clear then that there are rich alternatives to the 'mental disorder' paradigm, which rest on an African reification of consciousness and the attendant value systems inherent in those appraisals of human life. What is critical about these approaches is that they strive to respond to the claims that human psychology is only to be conceived in Eurocentric terms.

2.4 Yoruba Traditional Medicine

This study investigates the healing practices of Yoruba traditional mental health practitioners employing an interpretative phenomenology. The researcher is concerned with adding to the literature on alternative conceptions of mental health, and hopes to follow in the intellectual traditions of Professor Lambo, whose objective it was to articulate a psychotherapeutic context that was not dependent on Eurocentric assumptions about mental illness, recovery and treatment.

The study is centred upon the gifted healers drawn from the Yoruba tribe in South-western Nigeria. Taye (2009, p.73) writes about their cosmological and metaphysical systems:

> [The Yoruba culture] is situated in the metaphysical belief in the supernatural beings such as Olodumare, the Orisas, the oku orun. This marks their belief in two planes of existence; Orun and Aye. Aye (and everything therein including human body and soul) is believed to be created by Olodumare and the Orisas who resides in Orun1. This informs their belief that the souls of the dead go to Orun, where it came from, to continue to live there. However, the requirement is that these souls must have fulfilled their mission in aye for them to be admitted to Orun to continue to live as ancestors. The souls of those who did not complete their mission before they died are believed to reincarnate and continue to live in aye until they complete their earthly mission. These reincarnated souls are referred to as *abarameji*, or *akudaaya.*

The Yoruba people are deeply entrenched in a paradigm that implicates the spiritual world as entangled in the supposedly 'ordinary' one. In this sense, Yoruba psychotherapeutic modalities seek to restore some balance to a problem by negotiating between *Orún* and *Ayé.* To the Yoruba therapist, reality is not singular, impersonal, mechanical and neutral; it is charged with stories, imbued with invisible energies, populated by spirits, and made healthy by an understanding of one's place in the divine scheme of things. Hence, Brelsford (1935) asserted that 'reality in the Western world has gone the way of attempting to master things; reality for the African is found in the region of the soul – not in the mastery of self or outer things, but in the acceptance of a life of acquiescence with beings and essences on a spiritual scale. In this fashion only is the native mystic. Not because of any pre-logical function of mind but merely because he is the possessor of a type of knowledge that teaches that reality consists in the relation not of men with things, but of men with other men, and of all men with spirits'.

2.5 Philosophical Traditions Guiding Research Orientation

This study draws heavily from the two philosophical traditions: social constructionism and critical discursive psychology. Social constructionism is concerned with the ways knowledge is framed, while critical discursive psychology is a rising trend that advocates a deconstruction of the so-called tenets of Eurocentric psychology. Indeed, critical psychology implies that we see psychology, hitherto unfettered by any ethnic affiliation as a result of its pretensions to universality, as Eurocentric psychology – giving opportunities for the articulation of thrillingly new and parallel ways of responding to the questions: what does it mean to be 'human'? What does it mean to well?

Is knowledge essentially the product of the West, and the by-product of Western systems? Mainstream psychology is founded on the logico-positivist ideas intimately connected with modernism (Waldron, 2010). But the advent of postmodernism is gradually undermining the foundations of modernism and the characteristic quest for objective knowledge that has defined psychological discourse and, more specifically, the institutional search for the laws of abnormality in psychotherapeutic discourse. It is therefore critical to note that 'with the emergence of postmodernism, the positivistic worldview of objective reality is being challenged. The postmodern worldview, as exemplified by the metatheory of **social constructionism**, has great influence on our understanding of how knowledge is

constructed and how intervention is carried out in different helping professions' (Shek & Lit, 2002, p.105).

The epistemological conflicts underlying the current debates on the legitimacy of indigenous healing frameworks and the undesirous hegemonic influence of Western psychotherapy are constituted by two alternative, 'hardly compatible' discourses: objectivism and constructivism (Botella, 1998). The former is associated with positivism, which is largely discredited in academic discourse today, while the former is more associated with post-modernism. Both discourses are centered around the question: 'what is truth? How is knowledge produced? What is evidence and how can we tell if knowledge is legitimate or not?' Objectivism is characterized by the notions of truth as an objective referent, separate from the observer, existing regardless of the participation of potential knowers, and only accessible by the rigorous application of a system of rules or procedural accuracy. Using alternative appellations such as 'positivism', 'modernism' and 'received view', Botella (1998) concurs with the idea of objectivism as procedural quest for an objective referent by stating that 'the core assumption that identifies the discourse of objectivism is that Reality exists independently of the observer, and can be known with objective certainty if the right means are used. This objectivist view has its roots in Newtonian physics and in the worldview of Modernism, which influenced psychology in its historical origins. When applied to clinical psychology and psychotherapy, this discourse carries not only epistemological implications, but also methodological, technical, and ethical ones.' Objectivism searches for foundations of knowledge, and, in its quest, attempts to delineate true knowledge from false knowledge. Exploring the historical underpinnings of the evolution of objectivism and its centrality to scientific discourse is not an objective of this section or paper. It might suffice the reader, however, to understand how the epistemological project or quest for 'truth' was severely undermined by the critiques of important thinkers like Foucault, Wittgenstein (who dismissed the dogma that language and meaning must conform to a single logical structure – hence the advent of 'language games' (Weinberg, 2008)) Lyotard (and his stylized suspicion for metanarratives) and Derrida, who questioned the possibility of apprehending knowledge that is unshaped, untainted, and removed from human experience and advocated for the deconstruction of oppressive knowledge systems. In other words, the old regime of truth as correspondence with a pregiven suffered severely from new critiques that implicated the perceiver in the perceived and eradicated the

possibility of science as a neutral procedural correspondence with reality. Botella (1998) comments on constructivism:

As for the nature of knowledge, constructivism assumes that knowledge is a hypothetical (i.e., anticipatory) "construction". Thus, it departs from the traditional objectivist conception of knowledge as an internalised representation of reality. This constructivist assumption can be traced back to Kant's philosophy and to Popper's notion that no knowledge originates in pure observation, since every act of observation is theory laden... Constructivism cannot rely on the original/copy correspondence metaphor, since it departs from a representational conception of knowledge. Justification by means of the authority of truth is then regarded as an illusion, a "never achieved ideal or horizon concept"...

Akomolafe & Usifoh (2010, p.13) addressed the failing notion of truth as representation: 'Far from being an apolitical, self-evident pregiven, truth, as conceived today, was contextually spurned from a moment that was constrained to respond to its own endemic vagaries and crises. Today the notion faces a critical challenge in the chaotic vortices of postmodern thought.' Consequently, the idea of knowledge quickly spurned into constructivistic metaphors, which cast knowledge as constructed, myth, metaphorical, political, historical, engendered, situational, storied, participatory and local. Hence the triumph of the indigenous and the particular over the colonial and the universal. 'In effect, the triumph of the postmodern is possibly the realization of the socially constructed nature of reality and the interested observer, and truth is a deeply political process of change that is relative to the local hegemonies of interpretation. The postmodern radicalizes and decentralizes knowledge as 'interpretation and nothing but this. Things appear to us in the world only because we are in their midst and always already oriented toward seeking a specific meaning for them. In other words, we possess a preunderstanding that makes us interested subjects rather than neutral screens for an objective overview' (Akomolafe & Usifoh, 2010).

The implications of the postmodern moment for psychotherapeutic evidence and legitimacy are monumental. In the Nigerian situation, for instance, the current invisibility of traditional paradigms to governmental practice and the persistent refusal to recognize the inherent values brought to the fore by indigenous approaches to life and wellbeing become unjustified. If 'truth' is not the exclusive preserve of any one culture, logical structure, or procedure, then 'truth' is myth, co-constructed by culturally diverse groups – 'equally' owned

and performed by the Yoruba, Igbo, Urhobo, Hausa and the idealized West. The universalist claims of mainstream psychotherapy to legitimacy thus fails to hold further credence. In social constructivist conceptualizations, assessment, diagnosis and treatment are recast as political processes informed by localized myths about human be-ing, healing and deviance. Western psychotherapy is not superior in its ability to access pregivens about the nature of abnormality or therapeutic interventions; hence, orthodox clinical praxis is not the standard, and indigenous healing frameworks, deviations from that standard. Legitimacy cannot be granted any one healing tradition based on its supposed proximity to noumenal realities or extra-discursive therapeutic 'laws' – except as defined within the social space from which the practice emanates. The supposed hierarchy of healing frameworks thus disintegrates into decentralized arenas of healing praxis – conditioned by diverse cultures that may be perceived as being radically irreducibly unique and yet also allowing for confluences and similarities with other healing traditions.

Even more consequential to healing discourse in the postmodernist moment is the deconstruction of evidence or efficacy. Foreign to the postmodern re-conceptualizations of truth as myth and healing as intersubjective is the notion of efficacy, which retains undertones of modernist thought. Applied to psychotherapeutic discourse, efficacy studies are conducted to judge the success of an intervention strategy at producing certain behavioural outcomes. In sum, efficacy discourse is concerned with if psychotherapy really works. This discourse has been transferred to indigenous healing methods and the growing discomfort of their advocates with hegemonic mainstream psychotherapy. Zacharias (2006, p.381) states:

> In the past four decades, scientific evaluations of therapy outcomes have become a central preoccupation of western psychotherapy research. This intense research interest was provoked by the famous assertion by prominent psychologist Hans Eysenck, who in 1952 put into doubt the belief that rates of psychotherapeutic change outweigh the effects of spontaneous remission. Clearly, there have been fewer studies evaluating the effectiveness of indigenous treatment approaches. However, in a globalised world, dominated by hegemonic ideologies, concepts, and discourses, there is also an increasing need for traditional healing systems to participate in the transcultural discourse legitimising their essential positions and interests. Transcultural and ethnotherapeutic research in the field of medicine and psychotherapy can play a central role in achieving this goal.

Though, Zacharias (2006) goes on to state that Curanderismo results rival Western psychotherapy's, he notes that indigenous traditions need not subject their therapeutic outcomes to any hegemonic influence. The discourse of efficacy and therapeutic outcomes is

thus transformed from ‘what works’ or ‘what is true recovery’ to ‘what is meaningful’. Efficacy studies are often Trojan horses, subtly transmitting the values of one culture and the ideas of recovery and healing. The beliefs and perspectives articulated about what is expected of psychotherapy are not universally or objectively true. Indigenous healing paradigms can resist advances at colonization of therapeutic outcomes by insisting on the intersubjective nature of healing and the centrality of meaning to the therapeutic encounter.

Critical discursive psychology, as indicated earlier, guides this study. Critical discursive psychology is closely allied with social constructivist perspectives in its focus on how power differentials between contesting ideas about (in this case) healing and wellbeing are often ignored – creating hegemonies that are oppressive and insensitive to local, other needs. By questioning the conventional notion that how things are is how they should naturally be, critical psychology provides the narrative fodder to empower the marginalized to decisively reappraise their participation in systems that enforce silence and conformity to a single apparatus for understanding the world. The strengths of critical psychology, however, are not merely theoretical, but practical, and evinced in the lived experiences of indigenous peoples. By articulating the frustrations of non-mainstream practitioners and consumers of indigenous healing, critical psychology finds its crucial raison d’être. In developing this narrative, it is instructive to consider those frustrations, experiences and trends that reinforce the need for a decolonizing of therapeutic praxis and the recognition/celebration of indigenous healing systems. These rather disturbing, yet enlightening, trends should give occasion for reflection about practices that have gained a certain sort of ‘invisibility’ (Waldron, 2010) or cultural normativity, which allows for the operationalization of Western thought ‘within a hidden and unmarked space, resulting in its re-production and re-affirmation within discourse, social structures and institutional practices’. Hence, in this study, the researcher also addresses the need to speak new conceptions of social justice and equity to power, and redefine the ‘normal’.

2.6 Summary

In summary, the concept of mental illness is not as inevitable as it might seem. A compelling reappraisal of the origins of this concept implicate a Eurocentric Enlightenment epoch – otherwise called the Age of Reason – in which the institutionalization of ‘unreasonable’ elements in society led to the creation of asylums and the evolution of the subdisciplines of

psychiatry and psychotherapy. Consequently, the notion of mental illness is deeply Eurocentric. However, there have been alternative Afrocentric conceptions that stress the spiritual worldviews that are cherished on the continent. Concomitantly, ethnopsychotherapeutic studies have been conducted into indigenous conceptions of mental illness – following closely the intellectual traditions left behind by Lambo (1955). This study is founded in these streams of considerations, and is designed to explore Yoruba healers using an idiographic, explorative, qualitative method in order to generate themes that further articulate the uniqueness of their psychotherapeutic modalities.

CHAPTER THREE

METHOD

3.1 Introduction

This research project focused on the subjective nature of mental illness as lived and experienced by indigenous Yoruba mental healthcare practitioners. The study utilized a qualitative approach. This chapter describes the study in terms of the research paradigm and research design, the participants and their characteristics, sample and the sampling techniques, the procedure for data collection, the specific data analysis methodology, the conventions that informed evaluations of authenticity, and other elements appropriate to its full articulation. The first section explores the research paradigm (qualitative research/phenomenology) and the research method (interpretative phenomenological analysis [IPA]); the second section explores the participants in the study, how they were invited to participate in the research, how they were selected, and their characteristics as a group of experienced traditional healers; and, the final section articulates literature-based guidelines for determining rigor and quality of work in qualitative research.

Phenomenology served as the preferred paradigm for this research, and interpretative phenomenological analysis (IPA) (Smith, 1996; 1997) was the preferred research design. That is, the researcher employed a phenomenological, explorative, contextual and hermeneutic approach to explore, analyze, and interpret the narratives and meanings ascribed to the construct of mental illness by established Yoruba traditional healers.

3.2 Research Paradigm, Methodology and Design

A research design or methodology is the blueprint that guides how a study is conducted. According to Polit and Hungler (2004), methodology refers to a way of obtaining, organizing and analyzing data – and the design describes the logical sequence and procedures that determine how a research objective will be carried out. The literature base is replete with many iterations of the concept of methodology and design. For instance, Burns and Grove (2003) define methodology as including design, setting, sample, methodological limitations, and the data collection and analysis techniques used in a study. Henning (2004) describes

methodology as coherent group of methods that help the researcher answer the research questions that have motivated exploration. In other words, the research design is the coordinate system that guides the researcher from the moment he/she asks a question to the moment satisfactory answers are generated.

It is also important to note that research designs are influenced by the type of questions asked and the paradigms in which they are asked. Englander (2012, p.15) states that 'the chief criterion in determining what research method will be used should be the initial research question (based on research interest or research problem), not tradition or norms.' A research paradigm is a set of deeply held assumptions that prescribe procedures for the ways valuable knowledge is produced, and how it can be accessed. Specifically, a paradigm is an approach to solving a research problem. A paradigm is strongly influenced by worldviews about the nature of knowledge. For instance, if a researcher assumes the objectivity of a world independent of an observer, he/she is likely to frame questions that allow him to explore an accurate description of this world, and will strive to generate data that is free of bias, universally precise and true for all observers regardless of context. This paradigm is often called the positivist (quantitative) paradigm because it largely derives its procedure from a positivist worldview about knowledge. Data generated in such research will be reported in terms of cause-effect relationships, correlated variables, and statistical relevance. In the literature, this kind of research is called hypothetico-deductive research. On the other hand, if a researcher assumes that the world is socially created, shaped in our experiences, and reified in the meanings ascribed to these experiences, he/she will likely forego attempts to enhance objectivity – since nothing (in this worldview) is objective as such. This *interpretivist* approach to knowledge derives from the idea that the very act of observation changes what we conveniently take to be 'nature', which suggests that the world is deeply subjective. As such, it is impossible to attain an objective account of the world; the best that can be done is come to terms with our own biases and recognize how they shape the research outcomes. Further still, all data generated is a form of narrative, an account of a phenomenon as seen through the eyes of a researcher – with the possibility for other interpretations.

In this study, the researcher employed a hermeneutic phenomenological methodology called interpretative phenomenological analysis (IPA) to explore the meaning, subjective experiences and interpretations of mental illness and healing practices from the perspectives of Yoruba traditional healers. The methodology was deeply influenced by the social constructivist approach to knowledge, which assumes that knowledge is constructed, porous,

perspectival, contradictory, mytho-poetic, paradoxical and subjective. This study therefore is broadly classified as *qualitative* in terms of its assumptions, procedures, analysis methods, nature of generated data, and recommended ways of presenting data in a report.

3.2.1 Qualitative Research

This study employed a qualitative, phenomenological research design since the topic, assumptions, questions and objectives of the study were not appropriate for positivist and quantitative approaches. Qualitative research is naturalistic research, and is particularly adapted to the exploration of 'what' questions, which seek the subjective meaning behind experiences within multiple contexts. It might be helpful here to distinguish between quantitative research and qualitative research due to the unpopularity of the latter in Nigerian universities.

Hancock (1998, p.1) states that there are two approaches: quantitative research and qualitative research. Early forms of research originated in the natural sciences such as biology, chemistry, physics, geology etc. and was (sic) concerned with investigating things which we could observe and measure in some way. Such observations and measurements can be made objectively and repeated by other researchers. This process is referred to as "quantitative" research. Much later, along came researchers working in the social sciences: psychology, sociology, anthropology etc. They were interested in studying human behaviour and the social world inhabited by human beings. They found increasing difficulty in trying to explain human behaviour in simply measurable terms. Measurements tell us how often or how many people behave in a certain way but they do not adequately answer the question "why?" Research which attempts to increase our understanding of why things are the way they are in our social world and why people act the ways they do is "qualitative" research.

Golafshani (2003) elaborates more on what qualitative research is about:

> Qualitative research uses a naturalistic approach that seeks to understand phenomena in context-specific settings, such as real world setting where the researcher does not attempt to manipulate the phenomenon of interest. Qualitative research, broadly defined, means any kind of research that produces findings not arrived at by means of statistical procedures or other means of quantification and instead, the kind of research that produces

> findings arrived from real-world settings where the phenomenon of interest unfold (sic) naturally. Unlike quantitative researchers who seek causal determination, prediction, and generalization of findings, qualitative researchers seek instead illumination, understanding, and extrapolation to similar situations As such, the assumptions that make quantitative research 'work' are radically different from those of qualitative research.

Qualitative research and quantitative research are thus two very different ways of approaching 'reality'. The latter is based on the assumption that there is a single reality, and a host of procedures can bring us closer to apprehending it. Consequently, quantitative researchers value notions of objectivity, 'truth', 'reliability' and 'validity', attempt to eliminate bias and subjectivity in their research, and employ the use of numbers and various statistical analyses to calculate the degrees to which a difference or correlation is certain. Quantitative approaches to research are popular enough to be considered 'mainstream', and sustain a hegemonic influence over the academy, choice of research paradigm, and training of undergraduates and postgraduate students.

Qualitative research, on the other hand, approaches reality as story – that is, 'reality' is not singular, but perspectival, narrative, hermeneutic and polyvocal. Qualitative researchers in the social sciences attempt to bypass the ideas of neutrality that undergirds positivistic research by insisting that the researcher is always implicated in the researched. Experience is perspectival, irrevocably stained by the biography, development and position of the perceiver, and cannot be 'objectified'. As such, qualitative researchers seek to understand the meanings behind experiences surveyed, always noting that their final outcomes do not correspond with any objective given, but are in themselves stories about other stories. In qualitative research, theory is not established prior to engaging the field. Many quantitative researchers, bothered about the effectiveness and truth, often query qualitative researchers by asking what is to be gained from studying stories. We must keep in mind that this cross-paradigmatic inquiry often leads to deep misunderstandings about the merits of the latter. If we see reality as plural, subjective and storied, then studying stories limited to a context is a very important and commendable task.

The following is a list of definitive features of qualitative research as obtained in Hancock (1998):

- Qualitative research is concerned with the opinions, experiences and feelings of individuals producing subjective data.
- Qualitative research describes social phenomena as they occur naturally. No attempt is made to manipulate the situation under study as is the case with experimental quantitative research. Understanding of a situation is gained through an holistic perspective.
- Quantitative research depends on the ability to identify a set of variables. Data are used to develop concepts and theories that help us to understand the social world. This is an inductive approach to the development of theory.
- Quantitative research is deductive in that it tests theories which have already been proposed.
- Qualitative data are collected through direct encounters with individuals, through one to one interviews or group interviews or by observation. Data collection is time consuming. The intensive and time consuming nature of data collection necessitates the use of small samples. Different sampling techniques are used. In quantitative research, sampling seeks to demonstrate representativeness of findings through random selection of subjects. Qualitative sampling techniques are concerned with seeking information from specific groups and subgroups in the population.
- Criteria used to assess reliability and validity differ from those used in quantitative research

Qualitative research approaches and data analytic methods such as phenomenology and constructivist grounded theory respectively have experienced a rise in popularity in the social sciences for some time now – though it is still rather unpopular in psychology. Gergen and Gergen (1988) suppose that this is the case because the discipline suffers from its historical anxiety to be seen and treated as a hard science along the likes of physics, chemistry and biology. Many young researchers today, disenchanted from the perceived redundancy and irrelevance of positivistic traditions, are beginning to choose qualitative research as an emancipatory tool and as an exciting way to study unexplored topics and re-enchant their worlds.

Qualitative research, deeply connected to the postmodern critique of modern assumptions about truth and reality (Akomolafe & Usifoh, 2010), is particularly suited to the exploration of social issues, cultural perceptions, and experiences that cannot be satisfactorily subjected

to the impersonal procedures of quantification and statistical analysis. In this wise, qualitative research can bring to light the deep meanings members of a marginalized group have about their experiences, and, in sharing these stories, help to provoke social action, policy development, and new perspectives and values. Not surprisingly, qualitative research is deeply connected to action, community movements, emancipatory ideals, and indigenous expression (Denzin, 2005).

Qualitative research may be seen as a meta-paradigm that accommodates many other paradigms of research and consequently a plethora of methodologies and designs. Some of these are ethnography, phenomenology, grounded theory, ethnomethodology, symbolic interactionism, interpretative phenomenological analysis [IPA], narrative psychology, focus groups, discourse analysis, content analysis and cooperative inquiry (De Vos & Fouché, 1998; Smith, 2003). This qualitative study was grounded in phenomenological methodology and utilized interpretative phenomenological analysis to investigate, collect and interpret data generated from interviews with Yoruba traditional healers about their understanding and perspectives of mental illness, wellness and recovery.

3.2.2 Phenomenology as a Methodology

Braun and Clark (2006, p.5) stress that 'what is important [in qualitative research] is that as well as applying a method to data, researchers make their (epistemological and other) assumptions explicit. Qualitative psychologists need to be clear about what they are doing and why, and include the often-omitted 'how' they did their analysis in their reports.' Thus this subsection carefully examines phenomenology as a methodology of multiple strands and epistemological orientations. The objective is to ground the methodology in a research paradigm that summarily legitimizes the steps taken by the researcher in this study, conveys a sense of rigour and rootedness in the literature, and show its applicability to the research questions generated by the researcher.

Phenomenology is an inductive qualitative research paradigm and tradition that is derived originally from the 20th century philosophical traditions of Edmund Husserl [1859-1938] and subsequent reiterations by his student, Martin Heidegger [1889-1976] (Reiners, 2012). Edmund Husserl, a German mathematician, founded the philosophical movement of phenomenology. He believed that phenomenology was crucial to the exploration of

consciousness because it allows access to 'phenomena' by suspending all suppositions, so that the meaning of the individual's experience can be clearly adduced. In Husserl's conception, phenomenology was the study of 'intentionality', which involves the experience of perception, thought, memory, imagination, and emotion (Reiners, 2012). Reiners (2012, p.1) states that 'the critical question for Husserl was: What do we know as persons? Consequently, Husserl developed descriptive phenomenology, where every day conscious experiences were described while preconceived opinions were set aside or bracketed.' Husserl's brand of phenomenology is often known as descriptive phenomenology, which Spiegelberg (1975, p.69) defines as 'direct exploration, analysis, and description of a particular phenomenon, as free as possible from unexamined presuppositions, aiming at maximum intuitive presentation'.

Martin Heidegger, Husserl's student, who is responsible for hermeneutic phenomenology, 'rejected the theory of knowledge known as epistemology, and adopted ontology, the science of being. Heidegger developed interpretive phenomenology by extending hermeneutics, the philosophy of interpretation. He broadened hermeneutics by studying the concept of being in the world rather than knowing the world. Hermeneutics moves beyond the description or core concepts of the experience and seeks meanings that are embedded in everyday occurrences' (Reiners, 2012).

The rich philosophical traditions of Husserl and Heidegger – as well as other contributors to the discourse – are definitive in phenomenological research. An understanding of these discourses is often required of serious qualitative researchers who seek a theoretical coherence and synchronicity between their methods and the philosophies informing them.

It is important to note therefore that a critical distinction between Husserl's (descriptive) and Heidegger's (hermeneutic) phenomenological approaches is that the former aims to achieve transcendental subjectivity – a kind of idealistically neutral point of view – where the absoluteness of conscious existence could be established, while the latter is founded on the idea that the self and consciousness are not distinct – and so transcendental subjectivity, in terms of an objective description of conscious experience is not possible (Ehrich, 2005). Husserl's primary concern was to theoretically present a disciplined approach through which an observer could repress his experience, bias and dispositions in order to access a pristine, pure world of lived experiences and meanings. Ehrich (2005, p.2) was of the opinion that Husserl 'was interested in developing a means by which essential or universal knowledge

would be yielded. In order to achieve this, he proposed a number of "reductions" which involved individuals "bracketing" or suspending the natural attitude so they could experience a phenomenon in a new and unconventional way. One of these reductions was called a "transcendental reduction" which meant suspending everything in the world including one's own ego'. Husserl later adopted the concept of the 'life-world' because of criticisms leveled against the inherent idealism in the notion of 'transcendental subjectivity'.

Husserl believed that with the proper attitude, one could approximate a pre-reflective appreciation of the 'life-world', which is the experience of self, relationships and the world that an individual has. That is, by 'bracketing' one's own assumptions and experiences, it was possible to understand meanings in consciousness. An operationalization of the Husserlian philosophical tradition was attempted by Giorgi (1985), who sought to provide psychology with a rigorous descriptive empirical phenomenology that allowed the investigation of 'essences' or the invariant characteristics of a phenomenon.

Contrary to Husserl, Heidegger believed human existence is inextricably entangled with the world, a world of people, things, language, relationships and culture. Therefore it is impossible for anyone (researcher or participant for example) to opt to transcend or disconnect from these indelible facets of their lives in order to reveal some fundamental truth about lived experience (Larkin, Watts and Clifton, 2006). What Heidegger presented was the impossibility of stepping out of experience to see the 'world-of-experience-as-it-is'. In this respect, research is not a quest for universal truth about lived experiences – because the observer is indelibly bound up in shaping what that experience means. This suggests that no experience is objective, and that reality is co-reified from multiple perspectives. Accordingly, enquiry begins from the enquirer's perspective, from the basis of their experience. Research may therefore be read as an act of story-telling, a way of weaving perspectives (not facts) while being sensitive to how one's experience shapes another's, but not necessarily disturbed by the resistance offered by these impenetrable layers.

This Heideggerian counter-argument inspired the development and articulation of many hermeneutic methods of analysis – notable of which is interpretative phenomenological analysis (Smith, 1996; 1997). Interpretative phenomenological analysis [from now on, IPA] was presented by Jonathan Smith in his seminal paper of 1996. The method is grounded in psychological research, and has been utilized in health psychology, clinical psychology, counseling psychology (Brocki & Wearden, 2006) and fields that explore healthcare. Both

broad fields of the phenomenological spectrum have engendered corresponding research methods that are characteristically shaped by the philosophical underpinnings of Husserl's and Heidegger's submissions.

Though, phenomenology was 'written at a theoretical level, and not meant for applied research' (Ehrich, 2005, p.3) in the original articulations and counter-articulations of Husserl and Heidegger respectively, the discourse has given rise to multiple research methods – many of which are strongly oriented towards psychological subjects, and have informed qualitative researchers in psychology for decades. As such, phenomenology is a pluralistic family of methods, whose multifaceted history presents a great educational opportunity and also a challenge for those who seek to perform phenomenological research.

Broadly speaking, what is distinct to phenomenological research as opposed to positivist research is the focus on the meaning that an individual gives to the experience rather than a concern with causality or the frequency of certain actions, behavior patterns or occurrences. The phenomenon of concern in this study was the traditional healers' meanings given to the contextual experience of mental illness as well as their understandings of healing and recovery. It is important to note that an attempt to explain phenomena is not the focus of phenomenology; the focus is on description and interpretation in order to come to the rich meanings and lived experiences around the phenomenon.

Phenomenologists insist that all human beings are constantly seeking to articulate and make sense of their life worlds. Consequently, phenomenology explores everyday experiences which may be amorphous, unarticulated, and do not have clarity, precision or systematization (Giorgi, 1985). Phenomenology studies conscious experience ranging from perception, memory, imagination, thought, emotion, and desire to bodily awareness, social activity, as experienced from the subjective or first person point of view. According to Fischer (2006), making conscious experience accessible to investigation is the hallmark of the phenomenological method.

Phenomenology embraces a variety of methods such as participant observation, discussion and interviews as ways of collecting data (Creswell, 1994). The focus of data collection is to generate statements about the rich experiences and meaning spaces articulated by the participants. In contrast to nomothetic, mainstream research, which is deductive and begins by drawing hypotheses from already established theoretical frameworks in order to refute or fail to refute the phenomena studied, phenomenological studies are idiographic, discovery-

oriented and iterative – exploring concepts and meanings in as free a manner as possible, so that hypotheses are not traditionally generated from literature. As Groenewald (2004) and Moustakas (1994) claim, the aim of phenomenology is to return to the concrete as captured by the slogan 'back to the things themselves.'

Phenomenology there broadens and liberalizes philosophical inquiry by making it possible to sidestep concerns about what is real or not. The focus of phenomenological inquiry is experience and meaning.

There are therefore many variants of phenomenological research today, and many phenomenological researchers have a wealthy array of approaches from which to choose. Just as there are many variants of phenomenological philosophy under the rubric of the broad movement (Moran, 2000), there are many ways it has been operationalised in research. Often times this is confusing for the novice researcher, who is inundated with philosophical considerations that shape applied phenomenological research in contrasting – sometimes contradictory – ways. These competing visions of how to do phenomenology stem from different philosophical values, theoretical preferences as well as methodological procedures. Different forms are demanded according to the type of phenomenon under investigation and the kind of knowledge the researcher seeks. Rather than being fixed in stone, the different phenomenological approaches are dynamic and undergoing constant development as the field of qualitative research as a whole evolves.

3.2.2.1 Interpretative Phenomenological Analysis as Research Design

The goal of this research was to understand a human phenomenon and indigenous practitioners' experiences of this phenomenon (mental illness, recovery and wellness). This goal fits with the philosophy, strategies, and intentions of the interpretative phenomenological analysis [IPA] design, which is inspired by the Heideggerian hermeneutic tradition. This researcher preferred IPA because of his situated beliefs in the social construction of knowledge and being, multiple realities, and the intersubjective nature of meaning. This researcher therefore rejected a Husserlian-inspired analysis, and opted for a Heideggerian approach, which is operationalized in terms of iterative cycles of data engagement and a 'soft' awareness of one's involvement in the process of analysis – without the anxiety induced by seeking experiential invariants or 'eidetic reductions' (Ehrich, 2005).

IPA is a relatively new research method. It is intellectually connected to Heideggerian hermeneutics and interpretative traditions, is increasingly used in psychology, and has been instrumental in notable healthcare research especially in the UK (Smith, 2003). IPA is concerned with perceptions and meanings, and adheres to phenomenological thought in that it takes into account a person's subjective experiences and does not seek to produce an objective report of phenomena (Moodley, 2009). IPA assumes an interpretative stance, as opposed to a descriptive one. In the latter, a researcher assumes the invariance of a phenomenon; his objective is to accurately portray the phenomenon in his report. That is, 'to assume a descriptive stance and descriptive language is to seek to 'describe events or actions as they occur without any manipulation from the researcher' (Moodley, 2009, p.40) However, using interpretative language acknowledges that different individuals may attach different meanings to the same phenomena. In other words, IPA is based on the idea that the researcher *always* manipulates the researched – most times in unconscious ways, and that the very act of observation creates the phenomenon. As such, a universally appealing description is impossible from the standpoint of IPA. Therefore the process of research is never complete, and there is never an unequivocal account of an event.

Smith and Osborn (2003) are of the opinion that IPA involves a 'double-hermeneutic'; they state that in IPA research, the participants are attempting to make sense of their world, while the researcher is trying to make sense of the participants trying to make sense of their world. Thus IPA is a shared struggle in sense-making. Smith and Osborn (2003, p.54) state that IPA combines an empathic hermeneutics with a questioning hermeneutics. 'Thus, consistent with its phenomenological origins, IPA is concerned with trying to understand what it is like, from the point of view of the participants, to take their side. At the same time, a detailed IPA analysis can also involve asking critical questions of the texts from participants, such as the following: What is the person trying to achieve here? Is something leaking out here that wasn't intended? Do I have a sense of something going on here that maybe the participants themselves are less aware of?'

In this type of research, findings emerge from the interactions between the researcher and the participants as the research progresses (Creswell, 1998). Therefore, subjectivity is valued. In the stead of bracketing preconceptions and assumptions in advance of an enquiry (which is prescribed in other forms of phenomenological traditions), IPA researchers in psychology work from a Heideggerian perspective in examining cognitions, and try to delineate their basic understandings of a particular phenomenon but acknowledge that an awareness of these

'fore-conceptions' may not be brought to light until work has started in the interview or the analysis, i.e. until the phenomenon has started to emerge.

The researcher must therefore strive to assume a reflexive attitude, which means that he/she must try to be 'open' to the text (transcriptions from interviews with participants, for example), while seeking to question it in order to gain nuanced meanings that are otherwise not 'produced' from merely reading through.

3.2.2.2 Rationale for using Phenomenology

The goal of phenomenology is to make explicit what is implicit, to explore consciousness in terms of the meaning behind an experience. Phenomenologists insist that we cannot objectify human experience in the same way 'natural scientists' study objects, and that to isolate variables in an atomistic fashion (as is done in quantitative research) and examine their impact on behaviour without coming to terms with the nuances of the life-worlds in which those behaviours exist is to commit a categorical error. By sidestepping the issue of what is objectively real or not, and by trying to explore meaning and subjectivity, phenomenology recommends itself as a very important research tradition and a very humane method that can help reveal nuances about a phenomenon and challenge old notions. It is this very strength of phenomenology that the researcher found to be adaptable to his research purposes of examining challenging the monoculture of mental healthcare and 'discovering' other paradigms of diagnosis, treatment, wellbeing and recovery.

It is also important to note that phenomenology has for long been one of the most prominent psychopathological approaches within psychiatry, providing it with fruitful elements of theoretical, methodological and conceptual nature. This study sought to examine the meanings given to the experience of mental illness from the perspectives of Yoruba indigenous healers. The research portends new evolutionary pathways for understanding the phenomenon and its contextual nature, which may not yet be appreciated in the literature or assented to in mainstream psychopathological theoretical orientations. Moreover, the construct of mental illness is a highly complex one with gaps and paradoxes that are far from being resolved. For this reason, phenomenological methodology whose concern is to shed light upon the meanings of human experience, could be used effectively to explore a range of human experiences within psychopathology. For example, what is the nature of mental illness

and recovery? What does it mean to be a healer? A number of phenomenological research studies have been published in recent years, which have engaged related questions in clinical psychology (Briggs, 2010; Englander, 2007) Phenomenological explorations such as these have the potential to help us 'understand the complexity of human experience and gain a deeper understanding of the meaning of participants' experiences' (Ehrich, 2005, p.6).

3.2.3 Study Reliability and Validity

The construct of validity expresses the degree of confidence one has in an instrument to measure what it purports to measure. Reliability is the consistency of scores obtained from measuring events or phenomena. In quantitative research paradigms, the instrument must demonstrate consensus-based, satisfactory statistical scores to be deemed reliable and valid. Because quantitative methodologies are popular, qualitative researchers have often been unfairly requested to demonstrate rigor and quality of work within the constraints of reliability and validity. Due to the idiographic nature of qualitative research (as opposed to nomothetic research), and the focus on subjective meanings, determining reliability and validity does not apply to phenomenological methodology. Indeed, Yardley (2000) 'argues that reliability may be an inappropriate criteria (sic) against which to measure qualitative research if the purpose of the research is to offer just one of many possible interpretations as in the current study' (Briggs, 2010, p.150). It is important to note, however, that while phenomenological research is not tied to these criteria, there are other contextually relevant ways of increasing confidence about the authenticity of an investigation and the results generated. Phenomenological research approaches validity from the perspective of 'credibility' – that is, a conclusion inspires confidence because the arguments supporting it are credible (Terre Blanche et al., 2006). One way of demonstrating credibility, according to the literature, is to use the triangulation of multiple perspectives against which to check one's own position (Setsiba, 2012; Terre Blanche et al., 2006). Terre Blanche et al. (2006) further explain the different forms of triangulation. These are:

- Data triangulation: This involves the use of an assortment of data sources to balance the final conclusion in a study.
- Investigator triangulation: This involves the use of multiple researchers to evaluate and assess the processes and interpretations of the main researcher. This can be done during analysis or after analysis is complete.

- Theory triangulation: This brings the conclusions of the researcher on the data analyzed under the critical appraisal of multiple theoretical perspectives. 'Research findings can be incorporated into a more macro-analytical level of inference' (Setsiba, 2012, p.55).
- Methodological triangulation: This refers to the use of multiple methods to study a single problem; converging evidence from different sources such as interviewing, surveying, observation, review of documentary sources helps to strengthen credibility (Setsiba, 2012).

In this study, the researcher employed theoretical and methodological triangulation to increase confidence in the interpretations. This was done mainly using observational methods, which later aided memoing and a critical appraisal of the data during analysis. The researcher triangulated by examining a theory to highlight the research findings. Also, a journal was maintained throughout the research, which aided the researcher to suspend or set aside his biases 'and other knowledge of the phenomenon obtained from personal and scholarly sources' (Hein & Austin, 2001, p. 5).

3.3 Participants

Information regarding the participants, how they were recruited for this study, their characteristics, sampling techniques, inclusion criteria, how interviews were conducted, and the general procedure that the researcher utilized to carry out the study are included in this section.

3.3.1 Population and Sampling

Burns and Grove (2003) are of the opinion that the population in a study includes all the elements that meet the eligibility criteria for the study. In this case, the population consisted of all the Yoruba traditional healers in Ado-Odo Local Government, which, at the time of writing this report, was where the researcher resided and worked. Ado-Odo Local Government was selected because of convenience and proximity to the traditional healers (see Inclusion Criteria below).

A non-probability purposive (or purposeful) sampling technique was used in this study to recruit seven (7) Yoruba traditional healers with experience in taking care of and healing clients who presented with mental illness. One potential participant was excluded from the study because he pulled out of participating based on a lack of experience with treating mental illness. The researcher thanked him and stated that his participation was no longer required. In total, six (6) traditional healers were studied. IPA research is traditionally conducted with small numbers – with Smith and Osborn (2003) recommending around 5 to 6 persons. Accordingly, samples are generated intentionally – and not by chance. This contrasts with probability sampling used in nomothetic research, in which the objective is to enhance representativeness by randomly recruiting participants – with the hope that the results from manipulating the sample are generalizable to the population at large. However, in phenomenological research, the goal is to collect specific information in order to access deeper understandings of participants' experiences. Subjects are selected because of who they are and what they know, rather than by chance. Neumann (2000) identified types of sampling methods available to the phenomenological researcher. They include snowball, haphazard, deviant case, purposeful, quota, sequential and theoretical methods. This study utilized snowball and purposeful sampling method, in which traditional healers who met the criteria were approached about the study; these in turn made recommendations about other traditional healers in their vicinity.

At the outset of this study, the researcher contacted an indigene of Ado-Odo Local Government who was knowledgeable about the location and practices of Yoruba traditional healers, and understood the cultural constraints and intersubjective nuances associated with interacting with the healers. This individual [from now on, G1] acted as a gatekeeper. Siegle (2002) states that a gatekeeper in qualitative research is an individual or group that helps the researcher gain access to the population of concern. In this case, G1 was a middle-aged male, who spoke Yoruba fluently, and lived and worked in a location relatively equidistant to the far-flung traditional healers. Recruiting the support of G1 was crucial to the successful completion of the study as he helped the researcher build rapport with the traditional healers, who were initially suspicious about the objectives of the researcher. G1 was compensated monetarily for his services to the researcher.

Due to anticipated language barriers (since the Yoruba traditional healers were not likely to have experienced formal education, and thus would not have been able to communicate fluently in English), the researcher also recruited a co-researcher that could speak Yoruba

fluently, and whose task was to translate the questions of the researcher for the participant, and translate the responses of the participant for the researcher. The researcher could understand Yoruba, but had difficulties communicating in the language or holding a conversation for sustained periods of time. The co-researcher was briefed and coached on the research questions, the methodology, the objectives of the research, protocol concerning the semi-structured interviews, and the need to demonstrate an open, respectful attitude to the traditional healers. It might be important to note that many prospective co-researchers, who were invited by the researcher, turned down the offer to participate after learning about the study participants.

The researcher, the co-researcher and G1 made initial contact with the traditional healers in order to introduce the purpose and objectives of the research. During these rapport-enhancing meetings, there were no interviews or recordings. The researchers were properly introduced by G1, and were given some moments to speak. The researcher and the co-researcher introduced the researcher's university, the research problem, the objectives of the research, and some of the interview questions. The researchers also sought permission to use an audio recording device and a camera when the interviews begun, and read out consent forms that assured the participants of confidentiality, and also informed the participants of their right to withdraw from the interviews without the need to offer an explanation to the researcher. The participants expressed reluctance about appending their signatures to the forms. As such, consent was sought verbally and received verbally. In keeping with the context and preferences of the traditional healers, light conversations took place with themes covering their practice and how they had inherited their skills. Appointments were made to begin the interviews on an agreed upon date. The researchers met with all the traditional healers at least once before the proper interview protocols commenced. However, during this time, the researcher began making observations and started to keep a journal to record impressions about the work settings, speech patterns and nuances of the life-worlds of the participants. This form of memoing guided the construction of questions and later enriched IPA-inspired data analysis.

The following steps guided the research process:

1. Employ the services of a 'gatekeeper' (an individual whose positioning and credibility in the community of interest grants the researcher access to that community).

2. Employ the services of a skilled translator to resolve language constraints.

3. Brief the translator on the objectives and design of the research.

4. Make first introductory contact with indigenous practitioners.

5. Intimate indigenous practitioners about my research objectives.

6. Perform obligatory responsibilities that the gatekeeper might recommend will build rapport and trust – and which does not harm me.

7. Seek consent to record interviews and use observational aids to obtain other forms of data.

8. Perform semi-structured in-depth interviews of indigenous practitioners in eligibility/inclusion criteria.

9. Transcribe and translate emerging data obtained via repeated exposure to the practitioners.

10. Perform data analysis using IPA methods (Smith & Osborn, 2003).

3.3.2 Inclusion Criteria

The inclusion criteria determined who was eligible to participate in the study, and guided the researcher in selecting participants:

1. **Accessibility**: The participant must be known to the G1, and must be accessible by the researcher. The participant must also reside within 2 hours drive from the researcher's home.
2. **Years of Experience and Practice**: The healer must have 2 or more years of practice and 10 or more years of training under another experienced shaman. This standard might be arbitrary at first sight, but it allowed the researcher to focus on the practitioners who were most likely to be experienced in their practice – with concomitant successful treatment procedures.
3. **Mental Illness Healing Specialization**: The healers often possess a vast repertoire of skillsets not limited to the indigenous treatment of mental disorders alone. To be eligible for this study, a potential interviewee must assent to having the skillsets pertaining to the management of the condition.

4. Willingness to grant interview with electronic aids
5. **Lack of Professional Training in Mainstream Clinical Psychology**: The healer's training and practice must be situated within non-western, traditional frameworks.
6. **Demonstrated Acquaintance with Yoruba Cosmology and Cultural Understandings of the Phenomenon of Mental Illness**: The healer must be able to relate to generic Yoruba understandings and worldviews pertaining to the onset of psychopathology and how it is successfully managed.
7. Ability to communicate in Yoruba or English
8. **Reputation for Successful Intervention**: The healer must come recommended by the G1, and must be active in the practice of indigenous psychotherapy.
9. **Number of Clientele**: The healer must have intervened in no less than 5 'mental disorder' cases.

The researcher assessed potential participants' match with the inclusion criteria during the pilot and rapport-building visits to their places of practice. Out of the seven (7) participants selected by snowballing techniques and purposive methods, one (1) refused further participation. This was in spite of the fact that in a prior visit he had indicated readiness to be interviewed. A total of six (6) participants fit the inclusion criteria and were interviewed for this study. The inclusion criteria coupled with additional information that they elicited assisted the researcher to select an appropriate group of participants for the study.

3.3.3 Participants' Characteristics

Participants in this study were six (6) Yoruba traditional healers with experience in ameliorating complaints of mental disturbance. All the participants were men, and were from the Yoruba ethnic group of southwestern Nigeria. All the participants were trained in their shamanic arts by their fathers, and had no less than 10 years of combined training and practice. The participants' fields of expertise and the settings in which they gained it are summarized in the table (Table 1) below. All of them had experience treating mental illness; though only one reported that he specialized in healing mental illness, he also reported experiences with healing ailments not connected to psychopathology. The other five (5) participants reported on their abilities to address other non-specific concerns clients presented to them. Participants had between two to 40 years of formal practice providing mental health services to persons (mean=22.67, modes=20 and 27, standard deviation=12.48). Participants

were aged between 35 and 48 (mean=42.17, mode=46, standard deviation=5.35). Four (4) participants were able to estimate – with some difficulty – the number of mental illness cases they attended to within a month, while two (2) were unable to determine this, and simply said 'many' in spite of the gentle prodding of the researcher to provide figures. None of the participants had formal education in schools up to the university level. The participants [P1, P2, P3, P4, P5, and P6] were assigned labels to keep their identities confidential.

All the participants used herbs in their treatment modalities, and all except one consulted a Yoruba deity as part of diagnostic process. The participants' exposure to mainstream clinical practice or psychiatry was weighted across the dimensions of 'naïve', 'minimal' and 'sophisticated' – where 'naïve' stands for a passing awareness and rudimentary knowledge about Western psychotherapeutic frameworks and practices; 'minimal', a demonstrable knowledge about psychotherapy and/or limited participation or training; and 'sophisticated', grounding in non-indigenous theoretical orientations, utilization of established psychotherapeutic skillsets, and consultation of or shared practice with psychiatrists.

3.3.4 Locale of the Study

The study was conducted in Ado-Odo Local Government and in the bordering Yewa South Local Government (see Inclusion Criteria). Seven participants were contacted for this study. One potential participant declined further participation. Interviews were conducted in the homes of the traditional healers, which doubled as their work places.

3.3.5 Research Procedure

This section describes how data was collected, the methods used, the interview protocols that guided the conversations, as well as IPA-inspired data analysis that followed after collection and transcription of the interviews. Figure 1 gives an overview of the research approach adopted in this study (Ajjawi & Higgs, 2007).

Table 1: Socio-Demographic Characteristics of Participants

Participant	P1	P2	P3	P4	P5	P6
Speciality	Mental illness	Multiple	Multiple	Multiple	Multiple	Multiple
Years of Experience	40	27	2	20	27	20
Gender [M/F]	M	M	M	M	M	M
Age	48	37	46	41	46	35
Location	Ere, Ado-Odo	Idi-Ota, Ado-Odo	Olopanru, Ado-Odo	Ado-Odo	Igodonu, Ado-Odo	Ilobo, Yewa South
Place of Origin	Ere, Ado-Odo	Oniro, Ipokia	Olopanru, Ado-Odo	Ado-Odo	Igodonu, Ado-Odo	Ilobo, Yewa South
Ethnicity	Yoruba	Yoruba	Yoruba	Yoruba	Yoruba	Yoruba
Average Number of Clients (per month)	NA	NA	10	4	10	5
Source of Training	Trained by father	Trained by father	Trained by father	Trained by father	Trained by father	Trained by father
Hospice Clients	Yes	Yes	Sometimes	No	Sometimes	No
Exposure to and Awareness of Mainstream Clinical Practice [Naïve / Minimal / Sophisticated]	Naive	Naive	Naive	Naive	Minimal	Naive
Employment of Herbs	Yes	Yes	Yes	Yes	Yes	Yes
Employment of Divination	Yes	Yes	Yes	Yes	No	Yes
Employment of Non-traditional psychotherapeutic methods	No	No	No	No	No	No

3.3.5.1 Data Collection

Data collection in IPA research consists of a double-hermeneutic process, in which the participants attempt to understand their life-worlds, and the researcher attempts to understand the participants attempting to frame their experiences (Smith & Osborn, 2008). Moodley (2009, p.43) states that 'IPA merges empathetic hermeneutics with questioning hermeneutics. Empathetic hermeneutics is essentially an attempt to understand the world and lived experiences of the participants, while questioning hermeneutics involves the use of critical

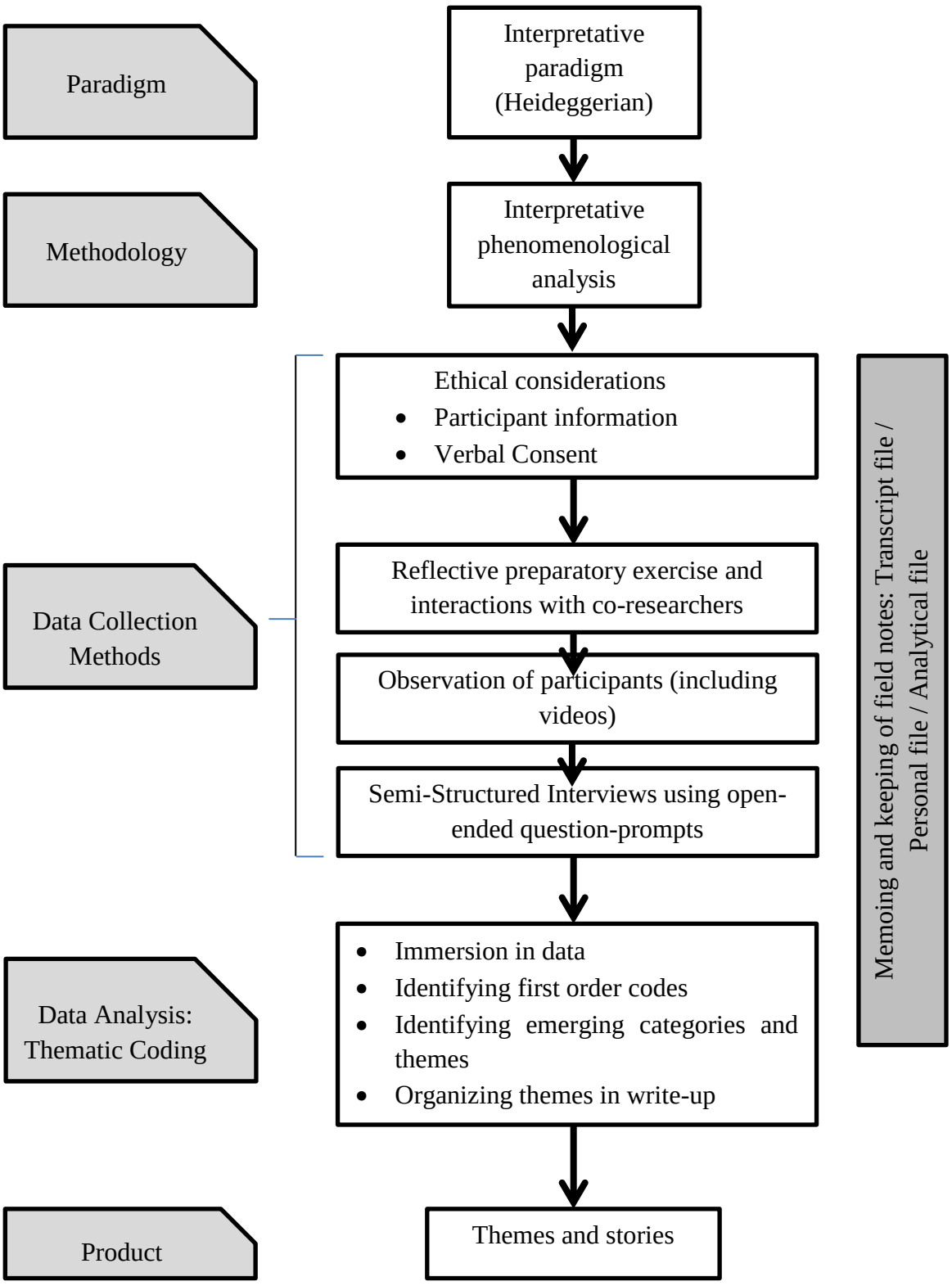
questions aimed at eliciting additional information relating to the phenomenon that is being studied'.

As such, semi-structured interviews were used to gather data. This is the most preferred data collection tool available to the interpretative phenomenological researcher, because it allows for a thematic structure to unfold in the conversation, while not being prescriptive about how these questions are asked or how they are responded to. This privileges the interviewee and gives him/her freedom to explore his/her experiences, memories, opinions, worldviews, relationships, and even the physical environment for ways to organize a response (Wimpenny & Gass, 2000). In the IPA interview context, a dialogue between the interviewer and the interviewee takes place – which serves the purpose of opening up the researcher to probe interesting areas not covered in the interview guide.

Arrangements were therefore made between the researchers, the G1, and the participants to meet at a mutually convenient time at their places of work/homes. Semi-structured interviews were conducted with each of the participants and lasted approximately one hour. A copy of the interviews transcript is provided in Appendix 1. Each of the interviews was recorded on a Nokia C7 phone with enhanced audio quality feedback and active noise cancellation features. The interviews were stored electronically in audio files, translated from Yoruba to English by research assistants who demonstrated proficiency in speaking the Yoruba language and also had experience with psychological subjects, and then transcribed verbatim by the interviewer.

Data need not be confined to interviews. It is also possible to use multiple sources such as diaries where the researcher has asked people to keep a journal documenting their thoughts and experiences. Other useful sources include personal accounts, letters, or returns from questionnaires. Because qualitative analysis entails rich descriptive data and represents a hermeneutic engagement of the reflexive researcher with the participants' comments, a skill known as memoing is often required to increase confidence about the outcomes of the study. Memos are reflective notes about what the researcher is learning from the data. With 'memoing', a researcher writes ideas and insights that are impressed upon him, and such insights are included in the data to be analyzed.

Figure 1: Overview of Research Approach



This phenomenological study of traditional healers' experiences and meanings attached to the concept of mental illness and recovery collected data using the following tools:

1. Semi-structured interviews (Smith & Osborn, 2003)
2. Observation
3. Memoing
4. Field Notes (Ajjawi & Higgs, 2007)

With regards to data collection using observation, the researcher arranged with the traditional healers to observe them carrying out their normal work tasks for at least one day. However because of the nature of their tasks and the confidentiality of their clientele, the participants were only willing to re-enact some of their healing procedures – especially in terms of diagnosing a problem via divination and deity consultation. One of the participants [P3] permitted a video recording of the procedure to enhance the researcher's observation and hermeneutic utilization subsequently.

Field notes are used by the phenomenological researcher to enhance data archiving during the study. Three types of field notes were recorded during the research process (Minichiello, Aroni, Timewell, and Alexander, 1995); they were the transcript file, personal file, and analytical file. The researcher kept and maintained a large folder which included the transcript file that contained raw data from the interviews; the personal file, containing a detailed chronological account of the participants and their settings, other people present (for instance, family members of the traditional healers and an accompanying friend of G1), and reflective notes on the research experience and methodological issues. The analytical file contained a detailed (critical) examination of the ideas that emerged in relation to the research questions as the research progressed. It also contained reflections and insights related to the research that influenced its direction. It was a means of prompting and recording reflexive inquiry by the researchers.

3.3.5.2 Interviews

IPA researchers usually collect data from (very loosely) semi-structured interviews where the interviewer has developed a 'prompt sheet' with a few main themes for discussion with the participants (Biggerstaff & Thompson, 2008). Biggerstaff and Thompson (2008, p.8) are of the opinion that 'this 'interview schedule' is merely the basis for a conversation: it is not

intended to be prescriptive and certainly not limiting in the sense of overriding the expressed interests of the participant. It is important that the interviewee take the lead during the conversation. Often the resulting interview data are very different from what the researcher might have anticipated.'

The interview schedule included questions generated from literature. The following guiding questions were used:

1. What does the term 'mental illness' mean to you?
2. What does it mean to recover from mental illness? What does mental health mean to you?
3. What do you understand as the reasons for 'mental illness'? In your understanding, how do these 'illnesses' emerge, and what does it take to address them?
4. Describe your experiences in treating mental illness. What steps do you take in determining the problems in particular cases?
5. Describe your worldviews and belief systems, and how they influence your approach to conceptualizing, identifying, and treating 'mental illness'.

3.3.5.3 Transcription

After each interview, the recordings were transcribed with meticulous accuracy, often including, for example, indications of pauses, mis-hearings, apparent mistakes and even speech dynamics where these are in any way remarkable. However, there were interviews that had 'dross' (which are communications or captured instances that are deemed not to be relevant to analysis), and such were consequently not transcribed. The transcripts are analyzed in conjunction with the original recordings and interview themes are identified which may or may not match those on the researcher's prompt sheet.

3.3.5.4 Data Analysis

Data analysis was performed according to IPA modalities suggested by Smith and Osborn (2003). It is important to note that phenomenological analysis is idiographic, non-prescriptive and non-absolute – in that the process engages the researcher's imagination, and yields narratives, subordinate themes and superordinate themes that capture meaning, but leaves

room for multiple perspectives. Data analysis in phenomenological psychology is not designed to yield explanations or generalizable comments; it is a hermeneutic process that reflects subjective meanings that deal with complexity, discovery and new information otherwise absent in nomothetic, quantitative research.

In IPA research, meanings are generated as a result of rigorous examinations of each individual transcript. Six (6) transcripts from six interviews were generated in Yoruba first, and then were translated to English by assisting researchers. The meanings generated in each case are then integrated to form a coherent report – usually represented in tables and stand-alone quotations with the researcher's interpretations given beneath them. This happens at the later stages of research.

Smith and Osborn (2003) identified four steps to performing IPA data analysis:

- **Step 1**: **Looking for themes in the first case**

  Analyzing the data began with full immersion in the first transcript – in an attempt to become intimate with the transcript (Smith & Osborn, 2003). After reading the first case multiple times, the researcher made notes on the left margin. Each time the transcript was analyzed new meanings emerged, which led to a cluster of nascent themes. The sweeping analysis went through each line of the text and focused on identifying phrases or vignettes (Smith & Osborn, 2003), which captured the quality of the texts. This initial coding process thus segued into the higher order creation of categories, which exemplified the important phrases. The same process was repeated for each of the transcripts.

- **Step 2: Looking for connections**

  All the emerging themes from the analyses were listed on a separate piece of paper. These themes were later grouped together to form subordinate and superordinate themes, wherein the latter was a higher order description and interpretation of the former. During progressive phenomenological thematic coding, which is progressive and hierarchical, generated codes often become distanced from the actual words of the participants. This cannot be avoided. However, the researcher could cross-check with the initial transcript to ensure that emerging themes remain consistent with the

happenings in the text. This was done in this study. Further still, themes that did not fit with the emerging structure or did not contain relevant information were discarded.

- **Step 3: Continuing the analysis with other cases**
  Themes that emerged in the first transcript shed light on other transcripts, and assisted with thematic coding. The template generated in the first transcript guided analysis in other texts. This helped to highlight similar themes as well as indicate new ones. After all the transcripts had been coded, and themes categorized into subordinate and superordinate classes, a comprehensive table of master themes was constructed.

- **Step 4: Writing up**
  The final stage of phenomenological analysis was concerned with translating the structure of hierarchical themes into a narrative account, which expanded the analysis. The analysis was discussed, explained and interpreted. The participants' words were distinguished from the researcher's interpretations as quotes – under which the researcher made explicit his perspectives.

3.4 Ensuring Research Quality

The double-hermeneutic dynamic of phenomenological analysis means that the researcher's perspectives are tasked to produce interpretations of the participants' own interpretations. The final product of IPA research – as is in most other qualitative methodologies – is a narrative account that demonstrates a living discussion with the transcripts has taken place, and that the researcher has grappled with the complexity of meaning behind the phenomenon explored. Ultimately, the final analysis of a researcher is only one perspective out of multiple other possible perspectives. As such, the report is an invitation to the reader to consider the interpretations of the researcher and make judgments about quality of work done.

Unlike Husserlian phenomenological research applications, the IPA researcher does not follow rigid protocols in analysis or in trying to 'bracket' his perspectives in order to produce an empirically verifiable account of psychological phenomena. However, there is an imperative for the IPA researcher to come to terms with his own bias and indicate, wherever possible, how his interpretations differ from the transcribed perspectives of the participants.

Babbi and Mouton (2001) and Van der Riet and Durrheim (2006) recommend strategies to ensure that bias is considerably accounted for. These strategies, which this study utilized, were transferability, dependability and conformability:

- **Transferability**: Transferability is not to be confused with generalizability as used in quantitative research. In this case, transferability, which is the degree to which the research could be applied to other contexts and with other participants, is attained by providing a comprehensive description of all aspects of the study – including the participants and the research contexts, within the constraints established by ethical considerations (Moodley, 2009). This study made considerable effort to describe the procedure, the participants, and the context of research.

- **Dependability**: This strategy is borne out by reading the transcripts repeatedly and cross-checking applied themes with the data (Krefting, 1991). This is in order to increase the extent to which the data is congruent with the interpretations or research findings of the researcher. In this study, the transcripts were multiple-checked and left for periods of time, and then analyzed again in order to produce congruence in interpretations.

- **Conformability:** To what extent did the findings reflect the research questions, the research process and the hermeneutic engagement and dispositions of the researcher? In phenomenological research, the role of the researcher is central to analysis. Ensuring conformability is therefore an issue of accounting for the role of the researcher in the dynamic of the study and in the reported findings. In order to ensure conformability, the researcher continuously reflected on his contributions to the study, and engaged his supervisor during the research process.

3.5 Ethical Considerations

The researcher obtained consent from the participants to record, transcribe, analyze and report the interviews so long as their identities were kept confidential and private. The thrust of this study was partly to bring attention to the indigenous practices of the participants. However, the nature of their practices remains largely frowned upon in an increasingly

religious context that demonizes their work. Consequently, the researcher was granted access to the healers with the understanding that they would be protected.

Each participant gave verbal consent to be taped, interviewed and discussed with – which was recorded by the researcher in field notes. Participants were duly informed about the research process, the objectives, the structure of the interviews, the possibility of follow-up discussions for clarification of transcribed interviews, and most importantly their right to withdraw from the interview and the study at any time – since participation was voluntary. This was done in the initial visits to the homes of the traditional healers.

At first, the researcher had intended to obtain printed letters seeking the informed consent of the participants, but when two of the participants expressed alarm and discomfort with the procedure, it was decided to employ a culturally appropriate way to seek consent. This arising development was discussed between the researchers and G1, who recommended seeking consent orally, after the objectives of the research and the nature of the study had been painstakingly explained to the potential participants. After oral consent was granted, albeit verbally – since this was in keeping with the preferences of the healers and the cultural context, the participants were offered monetary tokens or gifts. This was suggested by the G1. This was done not to enforce their participation or buy their time, but to further integrate the researchers into the cultural context of the participants. The monetary gifts (which were capped at 1000 Nigerian Naira per participant) were generously received, and blessings were invoked for the researchers by the grateful participants.

Interviews were conducted in the comfort of the traditional healers' homes and work places, and presented no harm to the interviewees.

CHAPTER FOUR

PRESENTATION AND INTERPRETATION OF RESULTS

4.1 Introduction

This study set out to explore the subjective meanings and perceptions about the phenomenon of mental illness, recovery, and the psychotherapeutic practices of Yoruba traditional healers. The participants in this study each provided rich, detailed accounts of their understandings of the phenomenon of mental illness and related constructs, how they conceptualize them, their intervention procedures, their diagnostic modalities, their aetiological frameworks (if any), treatment techniques, and evaluations of successful intermediation.

A total of six (6) Yoruba traditional healers, all males, took part in this study. All participants were over 35 years of age. The participants were interacted with on two separate dates, and interviewed once. Their limited availability meant that the researcher could not interact with them more than these times. Each interview lasted between 14 minutes to 60 minutes. All interviews were tape-recorded, translated and transcribed by the researcher and co-researchers who understood the Yoruba language. The researcher, following the guidelines of Smith and Osborn (2003) for interpretative phenomenological analysis, immersed himself in the interview transcripts many times in order to get a sense and feel of what the participants were trying to articulate. Analysis proceeded with general impressions and observations made on the left margin of each of the transcripts. Smith and Osborn (2003) insist that there are no predefined ways of making these observations, and that such initial notes may come in form of commentary, an insight into what the participant is saying, a phrase from the conversation that feels significant, a summary of the passage, or even a note on the use of language and the observed mannerisms of the participant. The creation of initial notes is chronological; that is, it follows the order in which the interview was taken. This process of creating initial notes stresses the double hermeneutic dynamics of IPA studies. Subsequently, first order themes – called ‘subordinate themes’ – are identified by clustering related initial notes together. This more analytic process is the affixation of high-concept phrases that reflect, more directly, the interpretations and orientations of the researcher, and creates a slight analytic distance from the text under scrutiny. However, the researcher is implored to return frequently to the transcript in an iterative manner – so that the responses of the participant are constantly kept

in focus. IPA modalities are saturated with the 'final' articulation of superordinate themes, which represent the double-hermeneutic of the participant and the researcher. Smith, Flowers, and Larkin (2009) argue that after individual themes have been developed for each participant, the researcher then looks for patterns across all of the cases in a process that produces super-ordinate themes. Super-ordinate themes represent a commonality of findings among the participants. In this case, as in all cases with phenomenological research, the themes identified do not represent the participants' truths alone; they are interpretations emerging from the researcher as well. As such, the findings of this study are not absolute, and there are other possible interpretations with the potential to generate additional or different themes.

The Smith et al., (2009) model and protocol for writing up an IPA report suggests that the researcher begin by 'taking the first super-ordinate theme, give a short statement outlining what it is. Then the most orderly sequence is to take each theme in turn and present evidence from each participant to support each theme' (p. 109). Additionally, there are two approaches for writing up results and discussion sections for an IPA study. In one approach the sections are kept separate while in the second the sections are merged. According to Smith et al., (2009), by merging the two sections the researcher is able to 'relate themes to the extant literature as [he is] going along' (p.113). The results and discussion sections of this study were merged. This enables the researcher to relate the emergent superordinate themes to extant literature in one narrative; and, by placing themes, interview excerpts, existing literature, and interpretative analysis in a single location, this presentation format offers a more convenient way for the reader to come to terms with the complexity of the study and its findings (Smith, 2003; Smith, Flowers, & Larkin, 2009; Smith & Osborne, 2003). Thus this chapter presents the themes generated from the phenomenological analysis of the transcripts, and discusses them – while showing interview excerpts from the interaction with the participants to back up the interpretations of the researcher. Similar studies will be discussed in consonance with the interpretations of the themes. The next chapter (Chapter Five) will therefore focus on the implications of the findings, conclusions reached by the researcher, and recommendations for further studies.

A total of nine (9) superordinate themes emerged that explicate how experienced traditional healers understand the phenomenon of mental illness from the experiential perspectives of their practice and their life-worlds. Each theme is presented followed by a participant quote to demonstrate grounding in the data. A total of nine (9) superordinate themes were generated

in this study, and discussed in this chapter. These themes collectively cover the experiences and perceptions of at least 4 out of 6 (~70%) of the Yoruba traditional healers interviewed.

4.2 Profile of the Participants

The participants in this study were identified with the active participation and guidance of a gatekeeper (G1), whose popularity and grounding in the communities of concern made it possible to have access to the traditional healers. Six (6) of the seven (7) traditional healers identified matched the criteria, and were thus included in the interviews.

All participants were male and of Yoruba descent. All participants, except one, were interviewed in Ado-Odo Local Government, where they lived and practiced as at the time of the interviews. The participants' ages ranged from 35 to 48 with a mean age of 42.17. The next subsections briefly describe the profiles of each participant as at the time of writing this report. To protect the identities of the participants, the researcher has replaced their names with codes (P1, P2, P3, P4, P5, and P6)

4.2.1 Participant [P1]

P1 is a 48 year old male traditional healer (*Oníségùn)* who has multiple specializations, but emphasizes his practice with clients who present with mental illness. He resides and works in Ere, Ado-Odo Local Government, Ogun State, Nigeria, and has been practicing since 1973. P1 learned his art from his father, who passed away in 2003.

4.2.2 Participant [P2]

P2 is a 37 year old male traditional healer (*Oníségùn)* who has multiple specializations and addresses clients who present with mental illness. He is originally from Oniro, Ipokia Local Government, but moved to Idi-Ota, Ado-Odo Local Government to live and practice traditional healing. At the time of the interviews were conducted, he had been engaged with traditional healing for 27 years. Like other participants, he was trained by his father.

4.2.3 Participant [P3]

P3 is a 46 year old male traditional healer (*Oníségùn)* who has multiple specializations and addresses clients who present with mental illness. He was born, resides, and works, in Olopanru, Ado-Odo Local Government. Though trained from childhood, P3 states that he formally inherited his father's practice in 2011.

4.2.4 Participant [P4]

P4 is a 41 year old herbalist and healer who, at the time of writing this report, had been practicing for 20 years. He resides and works in his home in Ado-Odo Local Government. P1 was trained by his father.

4.2.5 Participant [P5]

Aged 46 years, and born in Igodonu, Ado-Odo Local Government, P5 – at the time of compiling this report – had been practicing traditional healing for 27 years. P5 had also previously pursued a diploma at the Federal Neuropsychiatric Hospital in Aro, Abeokuta. His experiences with orthodox clinical settings were part of his disclosed narratives. Out of all the participants, P5 is the only one that does not accommodate consultation with gods. He claimed to intervene solely based on administration of herbal concoctions.

4.2.6 Participant [P6]

P6 was 35 years old at the time the interviews were conducted. He had been practicing for 20 years, and inherited a thriving traditional healing practice from his father. He was born in Ilobo, Yewa South Local Government, Ogun State.

4.3 Recalling Research Questions

The themes made explicit from the interpretative analysis of the transcript interviews generated rich answers to the research questions at the heart of the study. The study set out to

explore alternative paradigms that include conceptions of mental illness and wellbeing that were non-western or unorthodox. Interviews conducted were framed to reflect the research purposes of the study. The research questions for this study were:

1) What do the traditional healers in Ado Odo Local Government understand the nature of traditional healing to be? b) How do traditional healers perceive and valorise 'normality' and/or wellbeing?

2) How do the traditional mental health practitioners approach mental 'health' and mental 'illnesses'? b) What epistemological, ontological and situational constructs inform their approaches, techniques and evaluations of successful intervention?

3) What kinds of psychological problems do people bring to the attention of traditional healers in Ado Odo Local Government?

4) How do the practitioners explain the basis for the emergence of psychological problems in their clients? b) What techniques, rituals and performances are enacted by traditional healers in the 'treatment' of mental distress or the restoration of distressed persons into society?

5) What are the peculiarities of the setting or context under which the practitioners live and work?

6) How do the traditional practitioners understand and relate to Eurocentric orthodoxies and mainstream psychotherapeutic practices in the aetiology, course and treatment of mental illness?

The interpretative phenomenological analysis of the transcripts yielded considerably overlapping super- and sub-ordinate themes that reflected the research questions. Smith and Osborn (2003) suggest that the phenomenological researcher keep his actuating questions in mind as thematic coding is performed.

4.4 Interpretation of Themes Derived from Analysis

Nine superordinate themes were generated from the study. They are:

1. **Healing practice is non-formal, plural and inherited**
2. **Intervention as interaction with invisible realms**

3. **Understanding and classifications of mental illness in narratives of the particular**
4. **Healer identity and multiple competencies**
5. **The notion of Ayé**
6. **Mental illness and recovery as injustice and justice restored**
7. **Mental illness as shame**
8. **Origins of mental illness**
9. **Therapeutic relationship, intervention and recovery: dynamics**

Table 2 shows the unique spread of superordinate themes (coded [A] to [I]) and subthemes generated from the data with some overlap in participants' descriptions of their practice, ideas of mental illness and recovery. Tables 3, 4, 5, 6, 7, and 8 each show the themes generated from a specific participant (see Appendix for Transcripts of Interviews).

4.4.1 Healing practice is non-formal, plural and inherited

The participants' responses about their traditional practices as healers of mental illness generated data that highlighted aspects of their roles as healthcare providers, the nature of their vocation, and the peculiarities of their profession and settings. A notable theme that evolved across these conversations involved the lack of professional formality and the fluid nature of their practice. In contrast to modern psychotherapeutic institutions and their characteristic rigidity, emphasis on detached professionalism, and procedural exactitude, the traditional healing practices of the participants were organic, integrated with their everyday living, and treated as a special vocation in service to their communities. All participants evinced in their responses a feeling of heritage and an awareness of the historical import of their vocation. P3 noted the following when asked about how he obtained his training as a healer:

"My father had been doing this job for a very long time, while I was being raised. After my father died I took over the practice. Before his demise I had been assisting him with the job. Now that he's dead I have taken after him." (P3, 46 years, Interview 3, Row 8-9)

P2, more flamboyantly, stated the following:

"This work, it's my father's work. It was also my father's father's [paternal grandfather] *work. It was also my mother's father's* [maternal grandfather] *work. It was also my mother's mother's father's [mother's maternal grandfather] work. My mother's father's father and my*

Table 2: Common Themes and Subthemes in Participants' Conceptualization of Mental Illness

Common themes and subthemes in participants' conceptualization of mental illness			
	Superordinate themes	**Subordinate themes**	**Participants (N=6)**
A	**Healing practice is non-formal, plural and inherited**	Inherited healing practice	6
		Fluid and multiple specialization	
		Non-formal practice and application of skill	
		Non-formal intervention	
		Transferability of skill and knowledge	
B	**Intervention as interaction with invisible realms**	The inadequacy of Euro-American mental illness paradigms	4
		Diagnosis as divination	
		Dependence on deified beings for healing	
		Partnership with the paranormal in detecting and evoking healing	
		The agency and influence of sacred entities in mental health and wellness	
C	**Understanding and classifications of mental illness in narratives of the particular**	Describing mental illness (explanation as narrative contextualization)	6
		Understanding how mental illness emerges	
		Narrative, non-reductionistic differentiation of manifestations of mental illnesses	
		Emphasis on bodily, embodied understandings of mental illness	
		Story-based typology and aetiology	
		Types of mental illness are particularistic, descriptive and allegorical	
		Manifestations / symptoms of mental illness	
D	**Healer identity and multiple competencies**	Awareness of heritage, competence and self-identity as healer	6
		Assemblage of competencies and skill-sets	
E	**The notion of Ayé**	Non-ordinariness of objects and everyday life	4
		Non-pathologization of problems of living	
		Ayé and the non-ordinariness of objects and everyday life	
		Mental illness as access to other worlds	
		The inadequacy of Euro-American mental illness paradigms	
F	**Mental illness and recovery as injustice and justice restored**	Mental illness as injustice or perversion of sacred order and place	3
		Healing as justice or retribution	
		Healing as justice	
G	**Mental illness as shame**	Mental illness as shame	1
H	**Origins of mental illness**	How mental illness emerges	3
		Sources of mental illness	
I	**Therapeutic relationship, intervention and recovery: dynamics**	Memories of successful intervention	4
		Diagnosis and intervention procedures	
		Herbal administration as form of treatment	
		Duration of intervention and recovery	
		Maintaining wellness	
		Difficulty with managing clients	
		Diagnosis as non-divination	
		Lack of standardized healer-client relationships	
		Esoteric procedures and materials employed in treatment	
		Ascertaining success of treatment and recovery	
		Efficacy of intervention	
		Client belief and trust in healer	

Table 3: Superordinate themes and subthemes from Participant P1 [where R# is the specific row number in the case transcript where the associated comment or passage appears]

Interview [P1]	
Superordinate Themes	Subordinate Themes
[A] Healing practice is non-formal, plural and inherited	• Inherited healing practice [R4] • Fluid and multiple specialization [R8a] • Transferability of skill [R22, R42a] • Non-formal intervention [R28, R30] • Non-formal practice and application of skill [R34]
[B] Intervention as interaction with invisible realms	• The inadequacy of Euro-American mental illness paradigms [R32a, R32b, R42b] • Diagnosis as divination [R26a, R26b] • Dependence on deified beings for healing [R8b, R10a, R10b, R20]
[C] Understanding and classification of mental illness in narratives of the particular	• Describing mental illness (explanation as narrative contextualization) [R12a, R12b] • Understanding how mental illness emerges [R14a, R14b, R16, R18]

Table 4: Superordinate themes and subthemes from Participant P2 [where R# is the specific row number in the case transcript where the associated comment or passage appears]

Interview [P2]	
Superordinate Themes	Subordinate Themes
[A] Healing practice is non-formal, plural and inherited	• Inherited healing practice [R10] • Non-formal learning of healer [R56]
[D] Healer identity and multiple competencies	• Awareness of heritage, competence and self-identity as healer [R12, R14a, R16a, R28, R30, R32, R38a, R38c, R40b, R54d, R62] • Assemblage of competencies and skill-sets [R38b, R40a]
[C] Understanding and classification of mental illness as narratives of the particular	• Narrative, non-reductionistic differentiation of manifestations of mental illnesses [R14b, R14c, R16b, R20, R24a, R24b, R36, R40c, R52a] • Emphasis on bodily, embodied understandings of mental illness [R42, R50a]
[E] The notion of *Ayé*	• Non-ordinariness of objects and everyday life [R18, R54a, R54b,

	R54c] • Non-pathologization of problems of living [R50b] • The agency and influence of sacred entities in mental health and wellness [R50c] • Malicious agency and intentionality (ayé) [R52c, R52d, R52e] • The inadequacy of Euro-American mental illness paradigms [R44]
[F] Mental illness and recovery as injustice and justice restored	• Mental illness as injustice or perversion of sacred order and place [R52b, R58b, R60c]
[B] Intervention as interaction with invisible realms	• Partnership with the paranormal in detecting and evoking healing [R58a, R60a, R60b, R68, R70]

Table 5: Superordinate themes and subthemes from Participant P3 [where R# is the specific row number in the case transcript where the associated comment or passage appears]

Interview [P3]	
Superordinate Themes	Subordinate Themes
[A] Healing practice is non-formal, plural and inherited	• Inherited healing practice [R12, R64] • Non-formal relationships with clients [R30b]
[B] Intervention as interaction with invisible realms	• The agency and influence of sacred entities in mental health and wellness [R32]
[C] Understanding and classifications of mental illness in narratives of the particular	• Narrative, non-reductionistic understandings of mental illnesses [R20b, R30a, R34a, R34b, R34c, R40, R42a, R42b, R48b] • Story-based typology and aetiology [R16a, R38a, R38b, R44, R46] • Describing mental illness (explanation as narrative contextualization) [R16b, R18b, R24]
[D] Healer identity and multiple competencies	• Awareness of heritage, competence and self-identity as healer [R8, R10] • Assemblage of competencies and skill-sets [R28a] • Awareness of heritage, experience, competence and self-identity as healer [R46b, R76b]
[E] The notion of *Ayé*	• *Ayé* and the Non-ordinariness of objects and everyday life [R56] • The inadequacy or

	incommensurability of Euro-American mental illness paradigms [R36b, R74, R76, R78a, R78b, R78c, R80]
[F] Mental illness and recovery as injustice and justice restored	• Healing as justice or retribution [R26b, R60]
[G] Mental illness as shame	• Mental illness as shame [R72]
[H] Origins of mental illness	• How mental illness emerges [R18a, R20a, R50]
[I] Therapeutic relationship, intervention and recovery: dynamics	• Memories of successful intervention [R66, R70] • Diagnosis and intervention procedures [R14, R20c, R26a, R30c, R36a, R48a, R54, R58] • Herbal administration as form of treatment [R52] • Duration of intervention and recovery [R28b, R68]

Table 6: Superordinate themes and subthemes from Participant P4 [where R# is the specific row number in the case transcript where the associated comment or passage appears]

Interview [P4]	
Superordinate Themes	Subordinate Themes
[A] Healing practice is non-formal, plural and inherited	• Transferability of skill and knowledge [R34, R36b] • Inherited healing practice [R6]
[D] Healer identity and multiple competencies	• Awareness of heritage, competence and self-identity as healer [R8, R12, R18, R22a, R30a, R30b]
[C] Understanding and classification of mental illness as narratives of the particular	• Describing mental illness (explanation as narrative contextualization) [R16a, R28a, R28b]
[E] The notion of *Ayé*	• The inadequacy of Euro-American mental illness paradigms [R36a] • *Ayé* and the Non-ordinariness of objects and everyday life [R38a, R38b, R40a, R40b, R40c, R40d, R44a, R44b, R44c, R44d]
[F] Mental illness and recovery as injustice and justice restored	• Healing as justice [R22b]
[I] Therapeutic relationship, intervention and recovery: dynamics	• Maintaining Wellness [R42a, R42b] • Diagnosis and intervention procedures [R20a, R24] • Esoteric procedures and materials

	employed in treatment [R26a, R26b] • Difficulty with managing clients [R10]
[H] Origins of mental illness	• How mental illness emerges [R16b, R20b]

Table 7: Superordinate themes and subthemes from Participant P5 [where R# is the specific row number in the case transcript where the associated comment or passage appears]

Interview [P5]	
Superordinate Themes	Subordinate Themes
[A] Healing practice is non-formal, plural and inherited	• Inherited healing practice [R6, R8] • Non-formal relationships with clients [R44a]
[D] Healer identity and multiple competencies	• Awareness of heritage, competence and self-identity as healer [R12, R24a, R30a, R46, R50]
[C] Understanding and classification of mental illness as narratives of the particular	• Describing mental illness (explanation as narrative contextualization) [R24b] • Types of mental illness based are particularistic, descriptive and allegorical [R26] • Narrative, non-reductionistic differentiation of manifestations of mental illnesses [R20, R22]
[E] The notion of *Ayé*	• *Ayé* and the Non-ordinariness of objects and everyday life [R34d, R40, R42] • Mental illness as access to other worlds [R32] • The inadequacy of Euro-American mental illness paradigms [R34a, R34b, R34c]
[I] Therapeutic relationship, intervention and recovery: dynamics	• Diagnosis as non-divination [R52] • Lack of standardized healer-client relationships [R18] • Esoteric procedures and materials employed in treatment [R48] • Diagnosis and intervention procedures [R28, R30a, R30b, R36] • Ascertaining success of treatment and recovery [R44b, R44c]

Table 8: Superordinate themes and subthemes from Participant P6 [where R# is the specific row number in the case transcript where the associated comment or passage appears]

Interview [P6]	
Superordinate Themes	Subordinate Themes
[A] Healing practice is non-formal, plural and inherited	• Inherited healing practice [R6, R10] • Non-formal expertise [R26]
[D] Healer identity and multiple competencies	• Awareness of heritage, competence and self-identity as healer [R14, R32, R42a, R42b]
[C] Understanding and classification of mental illness as narratives of the particular	• Manifestations / symptoms of mental illness [R18a]
[I] Therapeutic relationship, intervention and recovery: dynamics	• Efficacy of intervention [R28, R32] • Client belief and trust in healer [R46]
[H] Origins of mental illness	• Sources of mental illness [R16, R20a, R20b, R20c]
[B] Intervention as interaction with invisible realms	• Partnership with the paranormal in detecting and evoking healing [R18b, R38a, R38b, R44, R40]

father's father [paternal grandfather] were friends. As they were friends, they helped each other and taught each other charms, taught each other important works. They taught one another and gave each other powers. My mother's father's father then told his child that 'the child you give birth to, it is my friend I want to give her to.' That was how my mother was given to my father. My father married 11 wives but out of all his children, I am the most skilled." (P2, 37 years, Interview 2, Row 28)

Owen (1995, p.19) supports this by stating that 'the shaman, priest and village elders have previously filled, meaning-giving, socially restorative roles'. That is, the healing practices of the traditional healers derive their legitimacy not from the mastery of externally imposed constraints or the award of professional certificates, but from their valued place and inherited functions within the communities they serve. All the participants likewise demonstrated that their skills and knowledge were received from their fathers or close relations (like an uncle), who were in turn custodians of lessons received from their own fathers.

Additionally, their responses yielded the subtheme of 'fluid and multiple specialization', which captured the fact that the healers had little or no predetermined boundaries of

expertise. Some of them claimed that they could solve almost any problem that came before them. P2 specifically noted that:

"There's no shamanic work I don't know, regarding people getting well. If you want someone to get pregnant, I know about it. If someone runs mad and you want us to take care of him, I know about it." (P2, Interview 2, Row 14)

"There is no kind of ailment brought to us that we do not address; there is no form of sickness that we can't work on. We work according to the job we have been given." (P3, Interview 3, Row 28)

Their cascading skillsets also included being able to cure stroke, grant people access to visas, and help the businesses of the clients to prosper:

"The work I do is much! I treat mentally challenged individuals, persons with stroke, those spiritually attacked by 'arrows', the barren, those processing their visa, as well as sick children. When I pray for these ones, they get okay afterwards." (P1, 48 years, Interview 1, Row 8)

This absence of rigid, atomized specializations informed their approach to intervention.

4.4.2 Intervention as interaction with invisible realms

A most striking master theme generated in the interviews involved the conceptualization of intervention techniques as ritualistic interactions with invisible realms. Much unlike orthodox psychotherapy and psychiatry, which reify psychopathological behaviours as emanations of bio-psychosocial substrates, the participants' reported that successful intervention in addressing mental illness was due to their abilities to draw energies from non-physical worlds to aid their detection of anomalies and their restorative inputs. Intervention was almost always framed as 'dependence on deified beings for healing', and diagnosis was reported to be culturally situated acts of divination or attempts to gain preternatural understanding of a problem.

When asked how the process of intervention usually commences, how he was able to detect psychopathological states and begin associated treatment, P3 answered by saying:

"If it is in the case of ***wèrè*** [a mentally disturbed person]*, he won't be able to sit the way we are all seated; besides his hands and legs would be tied when he is brought here, but even with that the individual would be struggling to cut loose. On seeing such, before I ask any question, I would enter into my room or closet as the case may be, and bring out my charm and speak words of incantation on him and ask him to calm down; only then can we now inquire from those who brought him/her. It is those who brought him/her that will now say how he has been behaving at home, at the work place, when it happened, where they have taken him to, and what was used before. They may report to us that they took him somewhere else, but did not pay close attention to what was used, and because there was no improvement, they have brought him to me. So on getting to my place we will then ask about the person's name, after which we will then know if we are to do* ***ìpábò*** *or* ***ètùtù*** [sacrificial ritual to appeal to spirits/gods for help]. *If it is required we will do it. After doing this, we will then commence the treatment." (P3, Interview 3, Row 54)*

This dependence on divination and the activity of spirits and gods for success was a theme that ran through other conversations:

"When we look, some people behave erratically…the words won't be coherent anymore. Some won't sleep. Some people run temperatures – temperatures that can lead to madness…if not treated quickly, will surely result in madness. We do that too. There are some that have been cursed. If ***Olórun*** *grants us success, we'll treat it. And there are some, there's no amount of effort that will heal him completely. Do you understand? He won't be completely healed." (P6, 35 years, Interview 6, Row 18)*

Therefore, most of the participants saw themselves as conduits for restorative powers. They believed that the agency and influence of sacred entities was paramount in healing a client. Without the activity of spirits or deities, some of the participants were often unwilling to proceed with a prospective client. The researcher observed in a video-recorded demonstration offered by P3 that they were able to ascertain the participation of their sacred partners by utilizing unique objects like cowries or bones and shells. In the use of these diagnostic tools, the participant [P3] took a number of cowries and squeezed them in his hand, while whispering into the enclosed fist. Sometimes he drank alcoholic beverages or unknown liquids and violently blew the contents of his mouth in the air, and then threw the cowries on a flat surface. The configuration of the cowries (whether they were lying face-down or up, how distant they were from each other, etc.) was reported to be a response from a sacred

entity. This partnership with the divine is central to the therapeutic practice of the traditional healer.

4.4.3 Understanding and classifications of mental illness in narratives of the particular

The use of the term 'mental illness' in framing the objectives and thematic frame of this study was provisional and merely employed in order to engage the participants in conversation about the range of mental problems they understood and treated. The researcher was hesitant about the assumptions of pathology inherent in the term, and presented these linguistic biases to the participants in order not to preclude their responses. Assumedly, one of the research objectives was to investigate the participants' conceptualization of 'mental illness' and recovery – as well as the supportive therapeutic techniques, theories and classificatory systems that enriched their practice.

This researcher observed, rather surprisingly, that in their attempts to articulate their understandings of mental illness, all the participants used non-reductionistic, story-based descriptions. That is, their explanations were narrative contextualizations of the assortment of problems that could be called mental illness. Instead of treating the constructs in atomic ways or as monolithic, objective referents, they used stories to explain their understandings of the concept. For instance, when asked to speak about his views on mental illness, P2 replied:

"About how I see a mad person? We can't say it all, it's my work. I told him the other day. We use rams to look at it. Anyone whose madness seems to be becoming too much, we use a ram to observe it. We use a mirror to look at his face, when we do this, he'll become well. We have an 'epe' that I use to look at him." (P2, Interview 2, Row 40)

When pressed further for details on the meaning of mental illness, P2 *(Interview 2, Rows 42, 44, 50)* responded in this way:

"You don't know who a mad person is? Mental problem, isn't it? That's what the White people call madness. God will not let you run mad. You can't talk exhaustively about madness. Secondly, if a person's hands are tied to the back, what has he become? Hasn't he become mad? If he is handcuffed, what has he become? Some people will wear clothes (unclear) what has he become? If you are looking at a mad man, if you are looking at him well, he will be doing this [blows and spits violently into the air]. It's the poisons in him that

he is spitting out. He will be spitting out the poisons. We have what we can do to mad people to make them sleep immediately."

P3 responded in the following way:

"About people who are mad, when they are brought here, if the case is fresh – and they bring him in – we would look at him for some time. If it is the sort of case that needs the cane, we will give him the cane. After we whip him, we observe him again, and then give him agbó [liquid herbal concoction] – the one we want to give him initially. If he sleeps with this initial drink, his case is still normal – not severe. His case won't take up to, let's say, 3 or 4 months, for a total cure. This means the charm or ailment as the case may be is still fresh on his body; this charm deprives an individual from not sleeping, because once the charm starts working the individual won't be able to get some sleep, he would be roaming round the house saying "give me something", while everyone else is asleep. If anyone is awake and observant about this change in behaviour, the person would bring him to us so as to know the nature of the sickness; that is when we will now administer the cane and the liquid drink for his body to calm down. If we now want to know the person that is responsible for is ailment we will check it to know if it is a woman or man that is responsible and if it is a man or a woman we will tell the family of the patient to inquire on who he/she has offended either within or outside. Perhaps the individual might have had a misunderstanding with somebody or may be somebody was to inherit the property of the father and decided to place madness on the individual so as not to remember the property." (P3, Interview 3, Row 30)

Similarly, P4 noted that:

"You know that a person who has turned into wèrè cannot be such as we are right now. He will be seeing many spirits; he has no more control over himself anymore. A person is said to be mentally challenged if he no longer thinks like a normal person. In some cases, it comes because of what a man smokes. That's number 1. Number 2… there are some cases in which the problem is inherited from family circles. There are some families in which when children are born, it is in their blood that one of them loses his mind. Number 3, when someone is cursed…they'll say he should misbehave – whatever he does he should not have any recollection of it." (P4, Interview 4, Row 16)

In another instance, P3 (Interview 3, Row 34) noted:

"A person that is mad is mad – there's no special name, but for us to know how it comes about… let's take for instance the present moment. You see the way we are having a conversation? Each of us responding to each other's questions? You ask, and I give an answer. If it were to be a mad person and you tell him to remove his clothes, he won't remove his clothes. He would rather be doing something totally different from what you are telling him to do. He could suddenly begin scattering things or vandalizing things around him when all you said was remove your cloth. He doesn't hear anything you say anymore. That is how you will know that something is wrong with this person."

In all instances, mental illness was explained situationally – without an attempt to offer a reductionistic analysis of the phenomenon. The participants understood the phenomena under investigation as embodied stories; there was a visceral, 'carnal', non-causal appraisal of the phenomena of mental illness and recovery. It may be noted that reductionistic explanations serve to understand complex systems by reducing them to simpler parts – thus creating a pyramidal hierarchy of analyses that increases in complexity as one works the way up. Rose (1998, p.176) states that 'the reductionist programme assumes that parts have ontological and possibly historical (developmental, evolutionary) primacy over wholes'. She continues by insisting that 'the worst problem arises when reductionism becomes an ideology, especially in the context of human behaviour, when it makes the claims to explain complex social phenomena (e.g. violence, alcoholism, the gender division of labour or sexual orientation) in terms of disordered molecular biology or genes. In doing so, ideological reductionism manifests a cascade of errors in method and logic: reification, arbitrary agglomeration, improper quantification, confusion of statistical artefact with biological reality, spurious localization and misplaced causality' (Rose, 1998, p.176). As such, the participants offered holistic, non-reductionistic appraisals of mental illness, which retained the complexity, embodiment, and paradox that characterizes situational analyses.

It could be argued that their 'refusal' or inability to frame their understandings in reductionistic fashion represents a cultural predisposition towards non-reification. The difference between the modern conceptions of mental illness and the participants' is therefore more than cosmetic or linguistic. As the participants demonstrated, and as is interpreted by this researcher, insanity is not a 'thing' or an essence; it cannot be objectified or reified as an essence with a universally observable structure. Lambo (1955; 1960) strongly indicated that psychosis and mental health were culture-bound constructs that were locatable in meaning systems. The participants' accounts make it possible to conceive mental illness as a complex

'relationship' between mythical and bodily realms that need not be reduced to simpler parts to be appreciated.

Consequently, there was no proper nosological framework or classification system for the various 'types' of mental illness disclosed. It was the researcher's first impression that the concept of a nosology wasn't properly understood when the participants were being interviewed. However, it became apparent to the researcher that the fluid, cascading, situation-based classification represented – on a deeper level of analysis – a way of engaging the world that was holistic, story-based, and non-essential.

When asked to speak about the types of mental illness – if any, P3 replied:

"Yes, there are different types. There are some cases in which the individual will not necessarily misbehave around the house, but he/she will not respond to conversation. Then there are other types in which when talking to him, he just stares into the distance and he/she will start putting on three clothes at one time; that's when people will know that he/she is running mad. And then there is another type, when he starts, he could begin beating people with anything he sees: a cutlass, a cane, a bottle, an axe, a knife. That type is called 'olororo' (heartless human being). There is also another type: the individual will not talk but he/she can walk from here to as far as Jos. He'll just be walking; he/she will not sleep. There is another type wherein the individual eats dead animals knocked down by cars on the highway. There's another type wherein he/she eats the excreta of chickens, rubs it on his body (his head, hands, legs and face) while talking to himself and wandering on the street – but after wandering around for a while he/she will come home and sleep. That type of person will send everybody that lives with him/she out of the house and only the individual will sleep in the house." (P3, Interview 3, Row 38)

When asked the same question, P5 stated more emphatically:

"Ah yes! There are. There are some – when I simply say: "Remove your clothes, walk out and continue walking into the forest!" It may be that the person did something offensive to another. That is what will happen – he will spend the rest of his days wandering about. There are some who ingest drugs like cocaine. Others have curses placed on them. There are some that come…that are so strong that we have to hold them down and bind them. Then we force down into their mouths an herbal concoction to get them to sleep." (P5, 46 years, Interview 5, Rows 24, 26, 28)

The participant P3 identified three closely related conditions that were associated with the construct of ***wèrè:***

*"These three types I called for you are different from each other. With **ìgbonná**, this is caused by **òtútù** [cold], but if quick care is not taken to use some medication so that he can be well, the individual will be behaving like a mad person and if left alone to rush outside, the person will be mistakenly identified as wèrè, whereas he/she is suffering from ìgbonná that later became wèrè. So you understand that they are different. With **inógíje**: this is when someone just suddenly places a curse on another being and that individual starts behaving in an abnormal way. This is different from **wèrè**, but the symptoms are similar." (P3, Interview 3, Row 46)*

When asked how he was able to differentiate between these conditions and what tools he employed to do this, he said:

"When these cases are presented before us, the first thing we do is to observe closely…the one who is wèrè…if you whip him with the cane or speak to him with words of incantation, if he is wèrè, he will calm down – though he will still behave in the wild ways that he wants to. But if it is inógíje, when words of incantation are spoken on the individual to put calm him down, he absolutely calms down and slumps; he won't cause any issue, he will just stare into nothing in particular; that's when you will know that this one is not in the category of people that are wèrè. The medication you use here would be much different than the one you'd use for wèrè. By the time we apply the medication – which is the eatable one – the individual's curse will come off his body. There's another type which is called wárápá –anyone who suffers from wárápá the individual will walk aimlessly and also fall down intermittently with foam coming out of his mouth. Most of the time, when people see this, they mistake him for wèrè: people see him and say he is mad whereas he is not mad. If they use medication, the individual will vomit the 'venom' inside him, and will be given treatment to calm him down." (P3, Interview 3, Row 48)

The participants therefore adduced a non-standardized classification system, which was based on shared observations and experiences with the conditions over time, and which was largely allegorical and grounded in the particular situation. This suggests that there is no strictly determined number or delineation of 'types' – as P2 evinced when he observed that there were 8 types of madness, but if there were time enough he could describe 201 types (P2, Interview 2, Row 14). He later described 8 'types' (P2, Interview 2, Rows 14-26):

- **Madness of 'wind' (wèrè atégùn)**: *"There's the 'madness of the wind'. There is the one who goes out and gets blown upon by the wind (atégun). The wind touches him; he begins to [behave in a particular way]. He is incoherent in his speech, and speaks to no one in particular. That's the one of the wind (wèrè atégùn)."*
- **Madness of 'breeze' (wèrè aféfé)**: *"Then there's the madness of the breeze, wherein the breeze was intentionally sent to him. They've sent 'something' to him. They've sent something to him. That's a mad person."*
- **Madness through exchanged clothes:** *"That one too wants to run mad. Abugije…that one, they use clothes to cause harm to that one. He'll be shouting. His eyes will be [describes it]! They use clothes to do that one."*
- **Misplaced hair:** *"Then there's one whose hair is taken away – that is the one that we see walking around."*
- **Misuse of psychoactive substances:** *"There's also a type where the person himself is responsible for his own condition, either by smoking 'weed', or by smoking cigarettes. Once such a person smokes, and they put even a strand of hair inside, he'll run mad."*
- **Enchanted names**: *"There's one where they take a person's name and his mother's name. They do terrible things with the names."*
- **Provoked by curses (asínwín):** *"There's one that is not good at all. That's the one they call 'asínwín'. This is done with a curse. They go to prepare curses and they curse the person. They will call his/her name and curse the person. Even the person whose name is not known…like how you are now, if someone should insult you and you have some powers, you could say "Ehen, you slapped me, you beat me", and then you point your hand, you point with shamanic powers and then turn the person mad with your powers."*
- **Through dreams (abisínwín):** *"This one hits a person from the dream, or a woman that just gave birth. This one is called 'abisínwín'. It hits someone from the dream. Yes, from the dream. Or maybe a woman gives birth and sees the blood and runs mad. That is called 'abisínwín'."*

The absence of any differential reduction was just as obvious in the ensuing discussions on the aetiology of the conditions. When discussing the causes of the conditions, P6 noted:

"Yes, there are many things. Like I said, some people think too much. Some people, it is smoking marijuana. For some, people are cursed. Some people are being 'done' to by others! There are some where the father suffered the same illness. As the father slept with the mother, it is compulsory that the child becomes… [Awaiting a response from the interviewer]?" (P6, Interview 6, Row 20)

The participants' fluid, anecdotal, non-reductionistic and grounded understandings of how mental illness or insanity emerges and its various forms of manifestations decidedly portrays a paradigm of non-reification and non-pathologization of these 'abnormal' states of consciousness.

4.4.4 Healer identity and multiple competencies

The non-medicalization and absence of any rigid standardization of these altered states of being suggested to the researcher that the healer's inherited identity, sense of competence and confidence in his restorative roles was crucial to the therapeutic relationship. This is because the locus of legitimacy and authenticity is not external to the healer as is the case with orthodox clinical psychologists and psychiatrists, whose authority to practice is derived from a certified mastery of a predetermined knowledge base outside of their histories. The Yoruba traditional healers, however, displayed a sense of ownership of their practice. When pressed for the foundation of their skill sets – in terms of questions seeking how they would know what to do in particular situations – the participants adduced their experiences and connections to *Ifá* (a Yoruba deity) as evidence of their authenticity. P2 stated:

"Do you know that there is a curtain in my 'Ifá' place over there? That curtain that you are looking at works like a television. Once I touch the person's face and cover it with my hand and do like so and so, call it how we want to call it, it'll light up for us and we'll see. That is what a shaman uses to eat. If someone runs mad and we see it, if we want, we can send the madness back to who it came from. We must send it back. Back to sender! Back to sender!" (P2, Interview 2, Row 60)

4.4.5 The notion of Ayé

A sharp contrast was drawn between modern psychotherapeutic assumptions about the world and the understandings of the participants about the universe. It seemed to be taken for granted by the participants that the world is infused with invisible forces and hidden energies, and everyday life is a dynamic negotiation of these composite realities. On the other hand, the mental illness paradigm (Pearson, 2004) supports a radically different understanding. Pearson (2004, p.2) explicates this worldview by unraveling prevalent notions about mental health:

> The current discourse in mental health reveal [sic] a set of beliefs about the way things are viewed by those engaging in the work of mental illness. Some examples of the ways of seeing mental health may include the following paradigms:
>
> - "Mental health is really about issues of mental illness"
> - "The crisis in mental health is about staffing numbers and beds"
> - "Mentally ill people in crisis must be treated in a hospital institution"
> - "Mentally ill people must take medication"

- "Mental health is about more and better mental illness services".
- "Mental illness services are under-funded and the issue of funding beds is central to the issue of mental health".
- "The media story about mental health is about violence of patients and threat to society".

The metanarrative that powers these assumptions is the belief that mental illness is entirely physical, and increasingly reductionistic explanations can help isolate the elements responsible for such disorders. The problems associated with this orientation are adduced by Levingston (2010, online):

> The medical historian Edward Shorter has remarked that, "If there is one central intellectual reality at the end of the twentieth century, it is that the biological approach to psychiatry -- treating mental illness as a genetically influenced disorder of the brain chemistry -- has been a smashing success." In fact, the contrary seems to be the case. Attempts to find a genetic basis for schizophrenia or bipolar disorder have led to the identification of a number of candidate genes, for example COMT, NRG1 and DTNBP1, each announced with enormous fanfare. Similarly, huge attention has been given to the discovery of an allele (variant) of one gene, 5-HTTLPR, which appears to make people liable to depression if they are exposed to negative life events. But, without exception, later studies have failed to replicate these findings. In one of the largest psychiatric genetic studies ever published, which appeared in the American Journal of Psychiatry last year, no association was found between any candidate gene and schizophrenia. A recent analysis of the evidence on 5-HTTLPR found no evidence that the gene directly causes depression, or that it makes people liable to become depressed if something unpleasant happens. However, the study observed a direct relationship between depression and adversity. As our mothers could have told us, bad experiences make us miserable. This last "discovery" is consistent with other evidence that life experiences shape even the most severe forms of mental illness. Research has consistently shown that migrants have at least a four times increased risk of psychosis compared to other groups, and the effect is most pronounced if they live in areas in which they are in a minority.

Taye (2009, p.75) distinguished between the reductionistic orientation of Western healthcare and that of Yoruba traditional healers:

> What this means is that while Western medicine is only occupied with one function; getting rid of the symptoms, African medicine performs three distinct functions: (1) Getting rid of the symptoms, (2) Identifying and removing the causes of the illness, and (3) Maintaining a holistic balance (including spiritual) in the patient15. With this, it becomes evident why African medicine is wider, deeper and more complex than the Western one. It may be argued that it is not true that Western medicine is not concerned with identifying and removing the causes of the illness. This is because mosquitoes are discovered as the cause of malaria fever and all efforts are being made to eradicate it. Also some illnesses have been discovered to have dirty water as

> their causes and attempts are being made to ensure clean water in order to remove the cause. STD and the warning against casual sex is another example. But the argument stands that Western medicine does not concern itself with the holistic (which includes seeking spiritual causes and healing) healing in the patient.

The participants' responses revealed a non-reductionistic approach that was informed by an enchanted view of the universe. It seemed natural to them to presume that life was the interplay of invisible, mystical entities, which needed to be appeased, interacted with, and sometimes feared. While the realities of these entities were taken as granted, the participants' responses betrayed a cautionary tone about the sometimes destructive influences of the unknown. In their conception, we are immersed in a field of spiritual energies, which accommodates even objects and events (like hair strands falling in ingested psychoactive substances) that may be seen as ordinary or inconsequential. This field of energy and awareness of invisible influences on one's life course was variously referred to as '*Ayé'*. P4 stated:

"The 'white man' cannot believe it – because over there they do not see that there are hidden forces (ayé) that people exploit to disturb others. But now things are changing – people are getting it. You know that now – through popular television programs like 'Nkan be' people are realizing that things happen. Now things are changing. This story of the doctor I told you…if I ran into someone and told them the tale they'd find it hard to believe. But now, on television, these mysteries are becoming very popular. The 'white man' will not see the way we see, because they do not believe people do things to other people. But here, we know that these forces are here – because we have terrible things in our hands. There are some things, for instance, that should not touch you. If I were to put this thing here on your body, you won't even give it any thought. You'd say: "Is this not alligator pepper?" Whereas here, this has powers and we have seen it. That's why we believe in the ways we do." (P4, Interview 4, Row 40)

P2 (Interview 2, Row 52) elaborated on how *ayé* is borne out:

"Sometimes, they put things in people's foods like poison. A friend can give a person, a mother can give her child, a father can give his child to eat. It's only God that wants us to do well, people don't want us to. The mouths that we feed are the ones that bite us. Yet you are the one working to feed him! Do you know what that means? For example, you own a company and you hire someone to work for you, you are the one paying him and his family is

enjoying, his parents are eating. You then offend him in a way that shouldn't be such a big deal but then he takes it personal and spoils something in your business. He has spoilt something good. What can cause madness? There are a lot of things that can cause madness. You see we humans in particular…with these our mouths, we must not say things that are not good to each other. God said we are children of authority; he said we will speak with authority and he will answer us and our questions with authority. That is why women…if your wife should give birth and is joking around with curses on your child and you tell her to stop and she refuses, chase her away. This is because she is spoiling the child's future; God will not spoil our futures. That is what is putting many mothers in trouble now. They'll say "You this child, you this wicked child, they will not enjoy you", and they themselves will not enjoy the child and the child's life will not be good; they will suffer together. My wife must not joke around with curses on my children. I don't do this with my children; neither do I do so with my siblings. If at all I am really offended, I will call him "bastard child from heaven!" Who is a "bastard child from heaven"? A child that I am clearly his father that clearly has a part of me in him…? Ok, a woman that gives birth for us that is swearing for the child, you know it is not good. A father that does the same, is that good? It is not good. We too that are parents cause a lot of troublesome things. Sometimes, when your child gives you 5 Naira, you must not tell anyone that he/she gave you money because people don't want you to eat well except sorrow; God will not let us eat sorrow. Many parents bring challenges upon their children. Some people, once the child is abroad, they'll say the child is now rich. Some people will be abroad for many years and still be unable to build the type of house we're sitting in now, till they die. With the child abroad, the relatives will now start calling and asking for money, if he doesn't answer, they'll turn him mad and he'll be sent home."

In this sense, the participants established that what was conveniently known as 'mental illness' was in most cases an influence of malicious or destructive forces on an individual. Unlike Eurocentric conceptions, which make out psychopathology to be impersonal, neutral and responsive to professional and formalized expertise, the notion of *Ayé* (which appears to be a prominent theme) for the participants meant that the world is conditioned by invisible forces and mediated by supra-political interests. The task of the healer was to challenge those forces that disturbed his clientele or negotiate restoration in a way that was amicable.

"May Olórun have mercy on us! As we are here, we are forces (ayé) ourselves – and to the passers-by outside who don't understand what we are doing in here, we are ayé. Perhaps we are having a sinister meeting, they do not know. That's what we call ayé. And there are

higher powers. You know that? Right now, we believe that Olórun created us – and it is not only us that were created. Olorun created other beings different from us – you know? There are others who walk in the forest, there are spirits…You see, these spirits hide in the woods, but as we build more and more houses and expand, we encroach on their spaces so that they do not have any place to live. We can't blame them. So they sometimes possess a child, and disturb us. That is life. But powers are bigger than other powers." (P4, Interview 4, Row 44)

This holistic approach to mental health was supported by the evidential absence of less psychotic mental illnesses like depression, bipolar disorder, obsessive compulsive disorder, and grief – among others described in the DSM nosology – in their responses. The researcher interpreted this absence to suggest that the healers did not pathologize or medicalize what Szasz (1960) in his anti-psychiatric stance, called 'problems of living'. To them, healing was performed on notably extreme cases; there was no conceptualization or evidence of reification of neurosis. Intervention was articulated as a shamanic response to psychobiologic states (the use of herbs and the communication); however, in their understanding, these states were subsumed under, largely governed by, and dependent on spiritual/mystical context the client was located in. The implications for this absence of awareness or conceptualization of neurotic states are discussed in the next chapter.

Evidence to support the notion of Ayé was further adduced when some of the participants presented considerations about the penetrative features of mental states – that is, their clients often expressed the ability to see spirits 'in the compound' or dead persons about them. Additionally, a strong theme that emerged was the concomitant inadequacy of orthodox therapeutic paradigms and praxis. Most of the participants referred to modern psychotherapy and psychiatry as 'giving tablets', and sought to demonstrate how insufficient this was in meeting the holistic needs of a client. In some instances, they praised the craftsmanship of the 'white man', and suggested that energies were local – and thus they were unable to see or understand the phenomenon in the ways they did.

To this effect, P3 said:

"What the white people have knowledge about is how to build things – like this handset – they couple things together. If someone needs 'blood' in an engine they use there, they'll give the 'blood'; if it's the blood of a human, they'll give; if it's the blood of a goat, they'll give. When they are done combining, they'll add mercury and when finished, they'll put on their engine. How they treat their patients is very different from how we treat ours. They don't

pour palm oil on yam to appeal to the gods – we do. They are oblivious to all these things. We aren't." (P3, Interview 3, Row 80)

4.4.6 Mental illness and recovery as injustice and justice restored

In the life-worlds of the participants, everything was believed to have a place. 'Mental illness', so called, was a perversion of sacred order or a disturbance of shared harmony. In their statements, they used language that suggested to the researcher that their roles were much more complicated than merely being healers. For instance, P2 (Interview 2, Row 60) stated:

"That is what a shaman uses to eat. If someone runs mad and we see it, if we want, we can send the madness back to who it came from. We must send it back. Back to sender! Back to sender!"

P4 (Interview 4, Row 22) recalled a case in which he had to appeal to aggrieved parties to 'let go' of the client:

"That one wasn't difficult. As soon as he was brought I already knew what to use to treat him. There are some performances we do to treat people – we may not have the materials on ground, but we will find out. But if we find that there are other influences involved, perhaps in his family house or a woman somewhere he wronged and we ask him to seek forgiveness, and he is not forgiven we know what to do so the curse returns to the sender."

In this sense, recovery may be seen as a restoration of harmony in relationships. For a client who presented with mental problems, the healer arbitrated by performing rituals to determine whom the client had probably offended or malicious intentions influencing his condition. Intervention proceeded by going to meet these concerned parties. The participant (P4) noted that in some cases, if the parties were unwilling to release his client, he knew what to do to transfer the 'madness' to the persons – while obtaining his client's healing.

4.4.7 Mental illness as shame

At some point during the conversation with some of the participants, the researcher explored the question of if there were any unspecified advantages to be gained in the experience of mental illness. One of the participants responded by saying:

"There is nothing good about it; it's a public disgrace. God will not allow one to be wèrè. For instance, if I run mad, and I am healed and helped to a state of wellbeing, and my child offends me so that I beat him severely. When the child comes out of the house, people will inquire what he did to deserve such a beating from the father. The child says he did nothing. Then, people will begin to think that I am experiencing some sort of relapse; they'll say "Ah! That thing is walking over his body again!" Whereas it is the sin the child committed that provoked such anger from the father which resulted in a beating. But because I have had that experience, people will think this way. That's how embarrassing the case can affect an individual." (P3, Interview 3, Row 72)

In the researcher's perspective, P3 further emphasized the themes of non-essentialism and relationality by focusing on the interactional effects of the condition. Mental illness was seen as a problem because it is exterior to the individual, and stigmatizes his family and community.

4.4.8 Origins of mental illness

All the participants represented mental illness as a phenomenon of *Ayé*. Some emphasized substance intake, curses and family circumstances:

"In some cases, it comes because of what a man smokes. That's number 1. Number 2… there are some cases in which the problem is inherited from family circles. There are some families in which when children are born, it is in their blood that one of them loses his mind. Number 3, when someone is cursed…they'll say he should misbehave – whatever he does he should not have any recollection of it." (P4, Interview 4, Row 16)

4.4.9 Therapeutic relationship, intervention and recovery: dynamics

All the participants narrated experiences and perspectives from which the research explicated themes related to the therapeutic relationship between them and their clients, intervention procedures, and recovery. Though some themes were more prominent than others, there were other themes that added deeper hues to the evolving picture or story that the researcher attempts to articulate in this report. Some of these themes were:

- **Memories of successful intervention**

  A composite narrative about the sense of competence and identity the healer sustains in the therapeutic relationship has been developed under other master themes. To the researcher, the participants showed further evidence of being grounded in their practice by sharing memories of successful cases they had had in the past. P3 was eminently assured of his value in his community and the strength of his treatments when he said:

  "By the grace of god, everyone brought here has regained consciousness, and they have also gone returned to their normal daily activities and businesses." (P3, Interview 3, Row 66)

  It has been earlier noted that the confidence of the healer seems central to his practice. His expertise is not certified or legitimized by a body of knowledge external to his organic roots and history.

- **Diagnosis and intervention procedures**

  Making a diagnosis entails making informed observations and knowing what to do based on previous experiences and training:

  "When a person is brought, there are questions I ask which are part of what I was taught. You won't know what transpires, but within my spirit I know what to do – because that's my training. If it's a malicious spirit-force involved, I will know. Take for instance, the last patient I treated happened to be drug addict; he was coming from a saloon where he went to get his hair cut. On his way back he saw his friends taking igbó [psychoactive drugs ingested by smoking], so he joined. Suddenly a tiny piece of his hair dropped inside the mixture and he ingested it. And you know once such is ingested the person will turn mad." (P4, Interview 4, Row 22)

- **Herbal administration as form of treatment**

  The healers interviewed made mention of using herbal concoctions – sometimes as a sedative means of managing clients that were too violent, and other times as a diagnostic tool. The client's reaction to their herbal administration gave clues about the 'type' of mental illness the healer was to confront. Additionally, as this researcher observed at the end of the interview with P5, some herbal substances are taken leisurely and often offered to visitors. Managing clients often resulted in the healers responding violently as well. By using chains and the 'charmed cane', their intention was to subdue the wildness of the client, and make him or her amenable to their rituals. When asked about how he would cure a client with a particular condition, P3 noted that:

  "That one is simple; we will make herbal solution for the person. I just made one for an individual now which I just gave to him. For us to detect that it is ìgbonná the individual must have been running round the house aimlessly before appearing here, then only are we going to give him herbal solution. He doesn't need to be beaten at all. The individual will sweat it off and go to sleep; when he/she wakes up we will now give him a proper medication." (P3, Interview 3, Row 52)

- **Duration of intervention and recovery**

  The participants noted that pre-establishing a length of time for treatment was difficult, because this was dependent on the severity of the case.

  "There is no kind of ailment brought to us that we do not address; there is no form of sickness that we can't work on. We work according to the job we have been given. But in this very year that we are in we've not had any form of 'mental' cases apart from those that their businesses are not prospering well, or those that need promotion or those not feeling too well. But as at last year we treated 12 patients – which were manageable; but for cases that have gotten very severe (over 4 or 5 years – who has 'entered the market'), when we have treated for some time, we take them to my uncle's place because we have a house there where we tie them down and begin to treat them for a long period of time. The reason is that such a case has already gotten out of hand and it needs close monitoring, proper attention and care. It will take us about a year or two to cure such a person." (P3, Interview 3, Row 28)

P6, very early in the interview, insisted that there were some cases he rejected – and another participant observed that the threshold of no recovery was when a client had taken off all his clothes – showing that the healers thought there were constraints and limitations to what they could achieve:

"If it is a person who has gone naked, then it's beyond our powers, but if the patient is yet to go naked then there is assurance of good health after prayer." (P1, Interview 1, Row 10)

- **Maintaining wellness**

  When P4 was asked if there were any particular recommendations on how to completely avoid the destructive influences of *ayé*, he laughed and asserted that it was impossible to do so, and that, by extension, everyone had the potential to experience 'mental illness'. However, by maintaining one's place and living in ways that were respectful to one's community and family (which is not always going to be possible), one could live healthily:

  "What I will say is that we are often the architects of our own problems. When someone has money now, he'll let others know he has money – and that often annoys people. If we go gentle, there'll be no problem. Don't go beyond your boundaries; stay in your place. Don't go about drinking too much. One should watch oneself." (P4, Interview 4, Row 42)

- **Lack of standardized healer-client relationships**

  The healers maintained cordial relationships with their former clients, and continued to play other important roles in their lives. With regards to his clients, P1 (Interview 1, Row 40) said:

  "Yes, they come back from time to time to get herbs."

- **Esoteric procedures and materials employed in treatment**

  Three participants were emphatic about their inability to share some of their herbal formulas and divining techniques with the researcher. When asked if he could show us his herbs and other materials, P5 stated unequivocally:

  "No. I cannot."(P5, Interview 5, Row 48)

P3, however, demonstrated the ways he receives information, and performed some incantations to establish our true identities.

- **Ascertaining success of treatment and recovery**

  Detecting recovery was a matter of immersing the client in normal contexts and assigning him or her responsibilities. For instance, some of the participants spoke about sending their clients on errands and 'giving him a hoe' in order to see if he could perform in normal conditions.

  "We often send them on errands to see how they respond. When he answers like he ought to, we know he is alright. There are some that do not respond as they should. There are some who come with clients that have taken lots of marijuana – you can see it on their bodies. They look shrunken. We have what to use that 'wakes' their brains up again. And then we speak to their families to bring this and bring that. I put my clients in a separate room however; I take responsibility for them but keep them away from others, because they are often wild and can harm others." (P5, Interview 5, Row 44)

4.5 Summary

The participants' stories about their practices, their perspectives on mental illness and its treatment emerged from the research context, and offered a wealth of information. The narratives here represent experiences unique to them; however, as is indicated by a double hermeneutic exercise, meaning evolved between the researcher and the participants. The interview process gave them freedom to express their unique wisdoms. The researcher treated these 'voices' in accordance with best practices in interpretative phenomenological analysis, and with respect for their shared experiences.

CHAPTER FIVE

IMPLICATIONS, CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction

This chapter presents discussions about the paradigmatic implications of the main themes that emerged during interpretative phenomenological analysis of the data – as well as limitations and recommendations of the study. Insights were generated from the experiences, perceptions, meanings attached, and the feelings about mental illness and recovery. The main purpose of this IPA study was to describe the reflections of Yoruba traditional healers, and hermeneutically engage their articulations of their life-worlds and psychotherapeutic practices. In this sense, the study was ethnographic – in that it explored healers from a particular tribe. However, the method and design were phenomenological and discovery-oriented, and focused on exploring the meanings associated with the experience of insanity.

The researcher finds it pertinent here to revisit the notion of qualitative research as an exploratory tool, designed to gain understanding of underlying meanings, and provide insights into the setting of a problem, which may generate ideas for hypotheses in quantitative testing subsequently. The findings of this study are not couched as absolute truths, but represent the interpretations of the researcher.

5.2 Discussion of Findings

This interpretative study set out to find out how some Yoruba traditional healers make sense of healing, mental illness, and recovery. The notions of mental illness and recovery were treated as not-seen-before constructs. The initial goals of the research were tethered to the discovery of themes that could describe the experiences of the healers. The emergent goals, however, during analysis, became the articulation of paradigmatic differences between mainstream clinical practice and the mental health paradigm from which the participants operated.

Semi-structured interviews were conducted with guiding open-ended questions. Interviews were translated from Yoruba to English, and transcribed. The researcher spent considerable

time immersing himself in the transcripts in order to gain a holistic sense of what the participants were trying to say. Hermeneutic analysis began with identifying initial codes, which were phrases that summarized the participants' comments. These initial comments were transformed into themes which represented the interpretations of the researcher. Higher order coding ensued with the identification of subordinate codes and master themes. The result of thematic coding was nine master themes, which were discussed in Chapter 4 alongside interview excerpts.

5.3 Themes Generated from the Data

The nine themes generated were:

1. Healing practice is non-formal, plural and inherited
2. Intervention as interaction with invisible realms
3. Understanding and classifications of mental illness in narratives of the particular
4. Healer identity and multiple competencies
5. The notion of Ayé
6. Mental illness and recovery as injustice and justice restored
7. Mental illness as shame
8. Origins of mental illness
9. Therapeutic relationship, intervention and recovery: dynamics

Each of the themes explicates the meanings attached to the phenomenon of mental illness, recovery and healing as narrated by the participants. Additionally the themes identify perspectives about the (aetiology) causes of mental illness, the classification system, diagnostic mechanisms, therapeutic techniques, the therapeutic relationship, and the commensurability of the indigenous healing paradigm to orthodox clinical frameworks. The following sections discuss the implications and utility of these findings, identify limitations of the study, and make recommendations for further research.

5.4 Implications for Clinical Practice and Indigenous Research

Smith and Osborn (2003) suggest that phenomenological research allows researchers to adduce new, often surprising conclusions with regards to the emergent findings from their

data. This section presents some considerations that are based on literature as well as the researcher's interpretations of the experiences of the participants.

5.4.1 The Utility of Phenomenological Research to Clinical Practice

The utility of qualitative/phenomenological research is often debated. It is often assumed that the method does not present real benefits to healthcare discourse. This is partly due to the prevalence of quantitative research which yields statistical aggregates of certainty about results obtained. In contrast, interpretative phenomenological research presents themes, stories and narratives as results that capture the researcher's perspectives and reflections about a phenomenon studied. As a result, it is believed that quantitative research provides answers about the objective world, while qualitative research merely explores subjective meaning. However, from a social constructivist perspective, the discourse of objectivity is also subjective. Qualitative researchers do not study the subjective world in exclusion of objective reality; they study meaning and experiences with the understanding that this is really all there is. In other words, qualitative researchers usually see the world as a series of meaningful constructs and experiences – and thus prefer to examine the meanings that people ascribe to their experiences.

Far from being the case that phenomenological research has no value to clinical studies, there are important benefits to be gained from performing phenomenological analyses in the context of mental healthcare:

- **Deepening knowledge**: In the context of this study, Yoruba traditional healers were recruited for interviews exploring their concepts of mental illness. This study proved to be important because it provided insight and information otherwise not obtainable in quantitative research. Because the research did not seek to confirm pre-existing theories or hypotheses drawn from pre-existing frameworks, the participants were allowed to speak freely and respond in ways that explicated their life-worlds. The emergent data generated themes that grant insight not only into an alternative paradigm of mental health, but into the critical limitations and flaws of current models of healthcare. The knowledge obtained by the research also suggests approaches for facilitating mental healthcare delivery in innovative ways – other than merely expanding existing systems.

- **Allows for new quantitative studies**: Some of the striking 'themes' suggested by this study had to do with the importance of the healer-identity in the therapeutic relationship, the non-pathologization of most assumedly problematic behaviours, the absence of standardized aetiological systems, the fluidity of diagnostic and intervention techniques, the role of the healer as restorative agent, and the notion of *Ayé* as illustrative of the effusive forces at work in and around individuals. It was also noted that therapeutic landscapes are not neutral, universal or absolute. Some of the participants asserted that healing was a local phenomenon, and critical aspects of Eurocentric psychotherapy or psychiatry were not enough to address the needs of their communities. These interpretations form theoretical backdrops from which new hypotheses may be drawn and examined. For instance, in order to test the claim that healing is culturally constructed (and as such mental illness is culture-bound) a quantitative study may explore the comparative differences between cultural responses to a singular intervention protocol.

- **New policy frameworks**: The results of phenomenological research can aid in the formulation of new policies or halt the progress of already existing ones. In the instance of this study, the participants presented narratives that evinced the absence of rigid classification systems for psychopathology. This researcher suggested that this provides compelling reasons for non-integration of indigenous systems into mainstream clinical practice. This is because the rich traditions and worldviews of the participants studied might be done away with or silenced under the imperatives of structure and coherence. Phenomenological research therefore provides means of surfacing deep issues and making voices heard (Lester, 1999).

- **Providing holistic, contextually relevant care**: As Pringle, Drummond, McLafferty and Hendry (2011, p.23) state, '…historical methodologies were not necessarily designed to deal with people who are ill and outside their normal contexts and surroundings. With regard to positivistic research results, theory tends to be generated from the mean or middle ground of the findings, with less emphasis on the findings that fall outside these perimeters. However, it is those who come outside the 'norm' who are usually the very people in greater need of our attention.' The findings of this study reflect a theoretical framework that is not prominent in mainstream clinical

practice, and thus explains why many indigenous groups are turning away from orthodox mental healthcare.

- **Lifestyle changes and wellbeing**: One of the themes generated from this study was the suggestion that mental health is affected by lifestyle choices. That is, it is not enough to understand mental illness in reductionistic ways; we must look to prevalent disturbances in the lifestyle and holding worldview of the 'client'. This can only be done with the exploration of meaning and subjective experiences. Pringle et al. (2011, p.24) say that

> …unless we understand meanings, we cannot alter health behaviour and lifestyles. It is surely only by maintaining an open, adaptable approach that we can truly reach, hear, understand and access our participants' experiences, particularly of those who may be in greatest need of our support. Expansive, honest and reflective accounts may be less forthcoming and more difficult to access from participants if a rigid set of questions or a more structured interviewing technique are used. this argument could well extend to the data analysis process, which also requires researchers to be flexible.

5.4.2 The Paradigmatic Crises of Orthodox Clinical Practice

This study was articulated on the reflections of the researcher about the monoculture of Eurocentric psychotherapeutic practice – what with its reductionistic approach to aetiology, diagnosis, and intervention. The researcher problematized the singularity of healthcare delivery in non-western contexts, as well as its pretensions to universal validity and applicability. The motivation of the researcher was to seek alternative worldviews or constructions about mental health and illness – ones which supported holistic and situated narratives about wellbeing. This study was concerned with the worldviews and perspectives of Yoruba healers, and subsequently showed that their expectations and ideas for mental health and treatment cannot be accommodated in mainstream practice.

5.4.3 Changing the Language of Illness: Indigenous Imperatives

The themes generated from this study suggested that the mental illness paradigm of orthodox practice is a misnomer. In the conception of the Yoruba healers interviewed, the phenomenon of 'insanity' cannot be reduced to a set of elementary problems – the expulsion or

reconfiguration of which would immediately guarantee wellbeing. The healers described 'insanity' and various dimensions of it in narrative ways – and did not try to reduce it to simpler phenomena. In many instances, curing 'mental illness' was revisited as restoring justice to a 'victim' of *Ayé;* recovery was couched as re-entering proper relations with one's family, compound or community. Even though herbal concoctions were administered to clients, healing was not reduced to the effects of the drinks or substances; instead the healers saw healing as a restoration of balance. By retaining the complexity of the phenomenon, they were predisposed to seeing it as much more than an 'illness'. Indeed, Ebigbo (1995) explored the concept of 'harmony restoration' as a form of indigenous therapy that was more in keeping with the cosmogony of African people. This researcher suggests, based on the findings of this study, that the linguistic constraints and worldviews contained in the 'illness' paradigm cannot support the meaning frameworks of indigenous people like those that patronized the healers.

5.4.4 Constructing the 'Subject'

Louw's (2002) study on the historicity of psychology is crucial in articulating the effects the discipline has on human subjectivity. He argued that the discipline of psychology reflexively creates its own subject matter and then studies it. In other words, psychology is produced by, produces, and is an instance of its own subject matter – which suggests that the practice of clinical psychology, the symptomatic manifestations of specific mental illnesses, and the categorization of the self in ways that are amenable to the discipline are arbitrary. Louw (2002, p.3) suggested that because the 'very object of psychology, its subject matter, its vocabulary and its frameworks have been constituted historically in the Western world', there was a critical way in which mental illness was itself imported into non-Western cultures. With the advent of industrial capitalist societies came a need to create subjects that fit into the system. Thus, 'mental illness' is a creation of the 'mental illness paradigm'. Lambo's (1960) work exploring how cultural factors shaped the manifestation of psychosis was more than a mere allusion to Professor Johann Louw's submissions. He (Lambo) saw psychopathology not as a monolithic entity, but as 'local', culture-bound, and conditioned by the categories people embrace to make sense of their subjectivities or interior worlds. Lambo would therefore have agreed that the problem of mental illness could not be addressed within the paradigm that 'created' it in the first place; he would have supported the participants of this

study, whose narratives helped the researcher identify the contours of a radically different way of understanding 'insanity'. This study evinces that our received modern industrial contexts, our imported subjectivities and categories for reifying our experiences, as well as the very discipline and practice of psychotherapy and psychiatry are complicit in the perpetuation of mental illness. There is therefore a critical need to shift out of these paradigms into more holistic ones.

5.4.5 Healing is Local

The researcher interpreted the statements of the participants to suggest that manifestations of illness and healing/recovery were local processes. They conceded that the dispensing of 'tablets' to mainstream psychiatric patients had its place, and seemed to express regret that the 'white-man' did not understand the influence of *Ayé* on wellbeing and illness. They however suggested that that their present practices might not work if they were relocated to the West. The predisposition of mental health discourse is to understand mental illness as an objective referent – universally valid, monolithic, and singular. Some of the implications of this study are borne out in the culture-specificity of mental problems. This means we may no longer be able to treat mental illness as if it were a single condition. Instead, as the healers urge, we must understand that there are many ways mental problems are reified, and thus many ways to address them.

5.4.6 The Possibilities of Re-visioning Mental Illness as Emergence

This study evoked the potential to re-conceptualize mental illness as a form of spiritual emergence. Though the healers did not show evidence of understanding mental illness as a condition that could be benefited from, the themes generated in data analysis pointed to the need for a reconceptualization of the phenomenon – especially in ways that allowed new categories to emerge, and in ways that did not replicate the paradigmatic flaws of reductionistic investigation.

5.4.7 Rethinking Mainstream Integration as the Future for Indigenous Healing

One of the critical implications of this study was the need to exercise discretionary caution about the quest to integrate indigenous healing approaches into mainstream systems (Asonibare & Esere, 1999). As was evinced in the interviews, the participants came to reckon with their world in fluid, narrative, non-reductionistic, non-formal ways. This was also reflected in the absence of a rigid, reductionistic classification of symptoms or types of mental illness. The researcher argues that this absence is not an inadequacy, but is due to the cultural predispositions that informs the participants' practices. Hence, it is needful to consider the merits and demerits of integration into mainstream systems because while orthodoxy may introduce indigenous healing paradigms to a wider populace, it is also likely to suppress its distinct features (such as its non-formality and lack of standardized framework).

Oyebola (1981) and Offiong (1999) highlight the dangers of integration, and both suggest that the dominant paradigm stands a chance of swallowing the notable characteristics of traditional healing practices. They therefore insist that a form of complementarity can be brokered between mainstream practices and indigenous practices; that is, instead of seeking to legitimize indigenous frameworks by grafting them on to pre-existing hegemonies (thus, granting them 'height'), one can strive to build pluralistic platforms on which amplified psychotherapeutic strengths of both paradigms can be made available to the discerning potential client.

The researcher, based on observed trends and themes within the data generated from this study, shares the concerns of Oyebola (1981) and Offiong (1991) and posits that a full integration might hurt the particularity of traditional healing systems.

5.5 Limitations of the Study

A strength of this study is that by exploring the experiences of traditional expert healers, insights have been gained into an alternative worldview and understanding about mental illness. Consequently, these insights simultaneously enrich perspectives about the crucial limitations of mainstream mental healthcare. Previous studies have performed ethnographic investigations into the meanings behind mental illness and the general practices of traditional Yoruba mental healthcare (Awojoodu & Baran, 2009; Nwoko, 2009; Jegede, 2005; Taye,

2009). However, this study employed an interpretative phenomenological method, which provides more openness to the phenomena under investigation as perceived and experienced by participants. This openness to the field contributed in the generation of themes that may be explored in greater detail in further studies.

To many unfamiliar with the conditions of qualitative research, an assumed limitation of this study is the lack of representativeness and small sample size used. The study recruited six male traditional mental healers. Brocki and Wearden (2006), however, suggest that most studies employing IPA do not aim to achieve a representative sample in terms of either population or probability, while Touroni and Coyle (2002) argue that qualitative research seeks to produce in-depth analyses of a small group's accounts rather than representative samples and that knowledge is advanced through a series of detailed, small-scale studies. Conclusions drawn and findings made are thus limited to that particular group and generalisations should be approached with caution (Flowers, Smith, Sheeran & Beail, 1997).

Smith (1999, p.424) argues that 'from an idiographic perspective, it is important to find levels of analysis which enable us to see patterns across case studies while recognising the particularities of the individual lives from which these patterns emerge'. He suggests that such research should be judged first and foremost on how illuminating it is of the particular cases studied and that the "micro-level theorising should be richly informative of those particular individuals and may well be fairly modest in its claims to generalisation' (p. 413).

As a result the master themes derived from the six interviews are best understood as applying to the experiences and perceptions of the six participants and may be used to chart new pathways into indigenous healing systems.

In relation to the sample size, Smith (1996) asserts that IPA challenges the traditional linear relationship between the number of participants and the value of research. Smith and Osborn (2003) note that sample size depends on a number of factors and that there is no 'right' sample size (p. 54). As an idiographic method, small sample sizes are the norm in IPA as the analysis of large data sets may result in the loss of 'potentially subtle inflections of meaning' (p. 626) (Collins & Nicolson, 2002) and a consensus towards the use of smaller sample sizes seems to be emerging (Smith, 2004; Reid et al., 2005). Smith and Osborn (2003) also suggest that IPA sampling tends to be purposive and broadly homogenous as a small sample size can provide a sufficient perspective given adequate contextualisation – IPA studies are concerned with examining divergence and convergence in smaller samples. The aim of this study, like

that of IPA was to select participants in order to illuminate a particular research question and to develop a full and interesting interpretation of the data and the researcher believes that this has been achieved (Briggs, 2010).

IPA is deeply subjective (Brocki & Wearden, 2006) and as such some may question whether the criteria for validity and reliability have been met. Reid, Flowers and Larkin (2005) suggest that a number of methodological features, such as 'transparency' of the results and 'reflexivity' in the interpretation processes, provide good benchmarks for ascertaining whether the generic qualitative 'good practice' guidelines set down by Elliott, Fischer and Rennie (1999) have been adhered to (Briggs, 2010). In this study, the researcher used excerpts from the interviews to clearly distinguish between his interpretations and the interpretations of the participants. However, transcripts were not shared with other researchers in order to arrive at a joint thematic framework. This lack of cross-validation may seem to prove to be limitation of the study. Yet, in defense of IPA modalities and researcher constraints, Yardley (2000), argues that reliability may be an inappropriate criterion against which to measure qualitative research especially if the intention of the researcher is to offer just one of many possible interpretations as in the current study (Briggs, 2010).

However, the study had limitations not related with the research design, which constrained the researcher's ability to plumb new depths of meaning in the recalled experiences and narratives of the traditional healers. Some of these were:

- **The Lack of Healer Availability:** The traditional healers, due to the esoteric nature of the practices, were at first suspicious of the researcher and his co-researchers. The researcher employed the services of a gatekeeper (G1) in anticipation of this reaction to the research process. Most of the participants had never heard been in a research context before, and preferred to grant informed consent orally. The researcher purposed to pay the healers a number of visits so that they could be acquainted with him. However, in spite of the fact that they eventually agreed to the interviews, they were largely unavailable for observational data collection, and preferred to keep some of their materials away from the research procedures.

- **The Gender Spread of Traditional Healers:** This researcher interviewed six male participants. However their gender was not part of the inclusion criteria. The research team considered the lack of female participants, and concluded that though it was a

limitation of the study, it was not detrimental to the research purposes. Literature abounds on the existence of women traditional healers (Struthers & Eschiti, 2005), who are valued members of their communities and just as revered as their male counterparts. However, one of the inclusion criteria for this study was proximity to the researcher's place of work. This may have precluded the participation of distant female healers. While this may be considered a limitation, it is probably just as important to note that even though there are female healers, they are rare compared to their male counterparts.

- **Lack of Access to Clients:** Qualitative studies are emergent, and sometimes the research objectives gain clarity when participants have been recruited, or even after data collection has occurred and the iterative process of data analysis has already begun (Smith, 1996). One of the initial research objectives of the study was to investigate clients' narratives of receiving healing from the herbalists. Present and former clients of the participants were to serve as a secondary source of data. It quickly became apparent that this was not going to be possible as initially intended. Two factors militated against this objective. The researchers learned that the former clients were culturally indisposed to sharing such information about their previous states with strangers. Additionally, it was difficult to gain access to present clients of the healers. One herbalist allowed access to present clients, but they were unwilling to speak with the researchers.

5.6 Recommendations

1. **Creation of complementary, pluralistic healthcare frameworks:** The research problem that inspired this study was based on the problematic monoculture of Eurocentric research. Widely held ideas about mental health are largely informed by the 'mental illness' paradigm. The continued subjectivization of people and medicalization of behaviour have reinforced the idea that the only research focus possible is merely incremental – that is, how to improve the paradigm. This research set out to confirm the availability of other paradigms. Employing a Heideggerian methodology, this study investigated the understandings of experienced healers of mental problems. As was expected, participants adduced new meanings of mental illness and highlighted the limitations of prevalent ideas. Arising from this study, this

researcher strongly recommends extra-academic frameworks that allow for the flourishing of indigenous approaches to wellbeing. These frameworks will allow for a less hegemonic stance on the subject of wellbeing, psychopathology, and recovery, and may come in form of bottom-up networks that connect needful persons to the services of the healers.

2. **Policy support for traditional healers:** The study investigated traditional healers, whose practices and perspectives about mental illness have resiliently survived in spite of the hegemonic presence of Western frameworks of understanding the phenomena in question. It is interesting to note that the healers shared information about the covert collaborations with orthodox clinical psychologists. They revealed that mainstream psychotherapists and psychiatrists often brought critical cases to them 'under the radar'. This tacit support for indigenous methods evinces an institutional discomfort with traditional healing practices or a corporate refusal to accept the limitations of mainstream paradigms. While this researcher does not feel inclined to support efforts at integrating traditional practices into mainstream systems, or to allow the economic imperatives and proclivities of mainstream systems to envelope traditional healing systems, he feels that the need for policy support could help these traditions thrive. Policy support could come in terms of institutional recognition of traditional healers like the participants of this study, complementary healthcare delivery, governmental frameworks and platforms that encourage traditional healing systems, and government-funded research into the benefits of these traditions.

3. **Investigation of African notions of mental illness and an informed dissociation from the DSM nosology:** Lambo (1954, 1955, 1959, 1960a, 1960b), Ebigbo (1995) among other researchers pioneered the need for cultural understandings of mental illness – and therefore called for the development of theories, classification systems, aetiological understandings, diagnostic procedures and treatment modalities that were in keeping with the preferences, worldviews and systems of being of the African / Nigerian. It is becoming quite apparent that the DSM manual and its reductionistic approach to classification, over-medicalization and over-pathologization of behaviours that have always been a part of human variance cannot meet the needs of Africans (Ebigbo, 1995). It may be important to note that recent events surrounding the publication of the 5th edition of the DSM framework have once again brought to

light the problems with that nosology. A Professor Emeritus at Duke University, Allen Frances, in a recent article to Huffington Post, exposed the following:

> The American Psychiatric Association has never once addressed the substantive questions raised about DSM-5. Instead, it has always followed the public relations recommendation to endlessly repeat the same meaningless mantra that many experts worked hard on DSM-5, that it reflects the latest in new science, and that it was the most open process ever. When more than 50 mental health associations requested an independent evidence based review of the controversial new proposals in DSM-5, APA brushed them off. Whenever the DSM-5 leaders and I have been invited to debate, they always refuse to meet face to face and to discuss the issues point by point. Their 'talking points', deaf ear, circle the wagons approach has deprived DSM-5 of a much needed opportunity to self correct before its rushed publication. (Frances, 2013)

The article goes on to highlight how many psychologists, social workers, healers and academics across the world are turning away from the DSM-5. This researcher believes that African ideas about mental illness should inform healing in Africa; this is not to suggest a naïve provincialism of methods or ideas about 'psychopathology'. There are interesting benefits to be gained from shared wisdoms. However, the DSM-5 and other such Western understandings and projects dominate the African landscape – and silence other approaches to mental health. As Lambo (1955) suggested in his seminal work on cultural factors influencing psychoses, there is increasing evidence that mental illness is not universal but cultural and local. There is therefore a need to develop, rediscover and reanimate new nosological frameworks that privilege the African person – instead of treating him as an afterthought.

4. **Teaching qualitative research methods to psychologists in training: '**Objectivity can sometimes become an obstacle in the search for truth' (Lambo, 1955, p.241). There is a relative absence of teaching on qualitative research and its benefits for discovery in Nigerian universities today. The prevalent paradigm is quantitative research, which is designed to confirm pre-existing theoretical frameworks that may or may not be sensitive to current political needs for self-expression on the African continent. This situation is in spite of the fact that qualitative methods best serve the purpose of 'giving voice to the voiceless' and finding relevance and grounding in the real needs of communities. This study highlights an investigation into themes and meanings otherwise invisible to the statistical imperatives of quantitative research.

The benefits of quantitative research are well understood; however, there is a need to complement this paradigm with qualitative research – so that African psychologists-in-training can learn to ask new questions, generate new discoveries, and investigate real needs. Qualitative research also addresses what may be taken as a proximity to complacency in the case of quantitative research. The former opens new pathways of exploration, and allows for new fields to emerge that could be crucially important to the wellbeing of African people.

5.7 Suggestions for Further Studies

The research was grounded in a motivation to discover an alternative paradigm to mainstream understandings and valorization of mental illness and mental health. The study employed a subjective, double-hermeneutic approach to data analysis – based on modalities articulated by Smith (1996) for IPA (interpretative phenomenological analysis), a qualitative approach emphatically developed for healthcare research in psychology. The study generated themes that can be seen as evocative of a wider cultural appreciation of mental illness, and which may be explored to further explicate their implications for a paradigm shift in mental healthcare. Some recommended further studies are:

- **Participatory-observational studies of healer practices:** A participatory-observational methodology will allow fuller immersion into the activities of the healers. It is quite clear from this study that much more information could be obtained about the activities of the herbalists. This is probably best obtained in form of sustained exposure to their practices, ideas, habits, and the nuances of their psychotherapeutic systems.

- **Hypothetico-deductive investigation of themes:** Qualitative research provides new themes and new theoretical frameworks from which quantitative researchers can draw hypotheses and ideas for investigation. Some proposed quantitative studies that may be adaptable to the conclusions of this research could be based on the investigation of culture-bound syndromes and manifestations of mental disorder.

- **Comparative studies between mainstream clinicians and traditional healers:** A mixed method approach could also be adopted to investigate differences and

similarities between mainstream clinicians and traditional mental health workers. This will better serve to inform decision-making on integration policies.

- **Further explicitation of Lambo's submissions on culture-bound psychiatric disorders:** Lambo's (1960) submissions on the relativity of psychiatric disorders and its culture-bound manifestations continue to inspire attempts to understand mental illness from an emic perspective. There is a need to explore the implications of this in bold research that challenges the hegemonic standings of mainstream psychotherapy. A number of studies can be put in place to perform a narrative analysis of Professor Adeoye Lambo's many submissions about the need for an African-centered psychotherapeutic framework.

- **Phenomenological investigations into the narratives of clients:** Understanding the meanings attached to the experiences of clients in traditional mental healthcare paradigms can highlight aspects of indigenous healing that are otherwise inaccessible by investigating herbalists alone. What are the clients' experiences? How do they understand their circumstances? Do they share the opinions and belief structures of their healers? Why do they prefer to seek help with the healers and not with orthodox clinical services? These questions are best answered in a phenomenological study with semi-structured interviews (such as this one), which would allow the clients to narrate their experiences freely and as openly as possible.

5.8 Conclusion

The current study was an attempt to explore how Yoruba traditional healers made sense of mental illness and recovery. Interpretative phenomenology analysis was adopted as a research method, and its aim was to explore the meaning, perceptions and the interpretations of healers. The results showed that mental illness was mostly perceived as a derivative phenomenon of *Ayé*, and that recovery was seen as retributive justice performed on the perpetrators of a condition. The results also indicated that the reductionistic approach to mental illness conceptualization was inadequate in understanding the phenomenon; there was an emphasis on the roles of spirits and invisible forces on the wellbeing of individuals. The respondents felt that their roles transcended merely providing care, and included advocacy for their clients. Recovery was narratively couched in terms of a rejuvenation of relationships.

There was also an absence of rigid classification systems and types of mental illness as participants adduced grounded and circumstance-based understandings of the phenomena. The results generated nine themes that may be explored in further studies, and which highlight the need to re-configure our mental healthcare landscapes for communities in need.

BIBLIOGRAPHY

Causes of mental illness (Traditional healers) - Types of mental illness among Yoruba tribe of Nigeria. (2010). Retrieved September 22, 2010, from Progressive Individual Resources, Inc.: http://pirimn.org/index.php?option=com_content&task=view&id=19&Itemid=34

Abbo, C. (2009). *Profiles and outcome of traditional healing practices for severe mental illnesses in two districts of Eastern Uganda.* Retrieved September 22, 2010, from Makarere University: http://diss.kib.ki.se/2009/978-91-7409-590-6/thesis.pdf

Adegoke, A. A. (2008). Factors influencing health beliefs among people in South West, Nigeria. *African Research Review, 2*(1), 177-197.

Agara, A. J., Makanjuola, A. B., & Morakinyo, O. (2008). Management of perceived mental health problems by spiritual healers: a Nigerian study. *Afr J Psychiatry, 11*, 113-118.

Aina, O. F. (2004). Mental illness and cultural issues in West African films: implications for orthodox psychiatric practice. *Med Humanities, 30*, 23-26.

Ajjawi, R., & Higgs, J. (2007, December). Using hermeneutic phenomenology to investigate how experienced practitioners learn to communicate clinical reasoning. *The Qualitative Report, 12*(4), 612-638.

Ake, C. (1979). *Social science as imperialism: The theory of political development.* Ibadan: Ibadan University Press.

Akinyela, M. (2002). De-colonizing our lives: Divining a post-colonial therapy. *The International Journal of Narrative Therapy and Community Work*(2), 32-43.

Akomolafe, A. C., & Usifoh, E. (2010). The pluralism of spiritual transformation and moral change: Heralds of a new opportunity for social action. *CHANGE Conference* (pp. 1-22). Lagos: University of Lagos.

Akomolafe, A. C. (2013). Decolonizing the notion of mental illness and healing in Nigeria, West Africa. *Annual Review of Critical Psychology*, 726-740.

Alatas, S. F. (2010). *Why read or teach the works of Marx.* Retrieved May 25, 2011, from Multiworld India: http://multiworldindia.org/wp-content/uploads/2010/05/Why-read-or-teach-the-works-of-Marx.pdf

Alvares, C. (2011, May 28). A critique of Eurocentric social science and the question of alternatives. *Economic & Political Weekly, 46*(22), 72-81.

Arowosegbe, J. O. (2008). The social sciences and knowledge production in Africa: The contribution of Claude Ake. *Afrika Spectrum, 43*(3), 333-351.

Asante, M. K. (2007). *An Afrocentric manifesto: Toward an African Renaissance.* Boston: Polity Press.

Asonibare, B., & Esere, M. O. (1999). Belief systems and attribution patterns of mental illness among Nigerians. *The Counsellor, 17*(1), 73-79.

Awojoodu, O., & Baran, D. (2009). Traditional Yoruba medicine in Nigeria: a comparative approach. *Bulletin of the Transilvania University of Brasov, 6*(51), 129-136.

Azibo, D. (1989). African-centered theses on mental health and a nosology of Black/African personality disorder. *Journal of Black Psychology, 15*(2), 173-214.

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

Biggerstaff, D., & Thompson, A. (2008). Interpretative phenomenological analysis (IPA): A qualitative methodology of choice in healthcare research. *Qualitative Research in Psychology*, 214-224.

Billy, J. R. (2009). *Back From the brink: decolonizing through the restoration of Secwepemc language, culture, and identity.* Retrieved June 21, 2011, from Simon Fraser University: http://summit.sfu.ca/item/9590

Botella, L. (1998, November). Clinical psychology, psychotherapy and mental health: contemporary issues and future dilemmas. *IJP, 3*(3).

Boroffka, A. (1980). Benedict Tanka's commentary and dramatized ideas on "Disease and Witchcraft in our Society". A Schreber case from the Cameroons. *Curare. Journal of Medical Anthropology, 3*(4), 225-240.

Bozalek, V. (2007). Power as resistance: Using students' subjugated knowledges to inform Social Work curriculum. *Enhancing Higher Education, Theory and Scholarship, Proceedings of the 30th HERDSA Annual Conference* (pp. 52-63). Adelaide: Higher Education Research and Development Society of Australasia, Inc.

Bracken, P., & Thomas, P. (2001). Postpsychiatry: A new direction for mental health. *BMJ, 322*, 724-727.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77-101.

Briggs, D. (2010, January). *A Qualitative Study Using Interpretative Phenomenological Analysis to Explore Chartered Counselling Psychologists Experiences of Supervision.* Retrieved April 23, 2013, from KMi: core.kmi.open.ac.uk/download/pdf/1933273

Broadhead, J. C., & Abas, M. (1996). Depression in Zimbabwe – investigations and community involvement in the generation of recommendations for service development. *Curare. Journal of Medical Anthropology, 19*(2), 227-232.

Brocki, J., & Wearden, A. (2006). A critical evaluation of the use of interpretative phenomenological analysis (IPA) in health psychology. *Psychology and Health, 21*(1), 87-108.

Burns, N., & Grove, S. K. (2003). *Understanding nursing research* (3rd ed.). Philadelphia: W. B. Saunders.

Burstin, J. (1935). *Schizophrenie et Mentalite Primitive.* Paris.

Carothers, J. C. (1947). A study of mental derangement in Africans and an attempt to explain its peculiarities, more especially in relation to the African attitude to life. *Journal of Mental Science, 93*(548).

Center for Addiction and Mental Health, C. I. (1999). *Key informants study: Report of the Caribbean community mapping project. A brief look at mental health issues in the Caribbean community of Toronto.* Toronto: Center for Addiction and Mental Health, Clarke Institute of Psychiatry.

Coffey, A., & Atkinson, P. 1996. *Making sense of qualitative data: Complementary research strategies.* Thousand Oaks, CA: Sage.

Cohen, D., & Crabtree, B. (2006, July). *Qualitative Research Guidelines Project.* Retrieved September 13, 2011, from Robert Wood Johnson Foundation: http://www.qualres.org/HomeAppr-3939.html

Constantine, M. G., Myers, L. J., Kindaichi, M., & Moore, J. L. (2004). Exploring indigenous mental health practices: the roles of healers and helpers in promoting well-being in people of color. *Counselling and Values*.

Constantine, M. G., Wilton, L., Gainor, K. A., & Lewis, E. L. (2002, September). Religious participation, spirituality, and coping among African American college students. *Journal of College Student Development*.

Constantine, M., Lewis, E., Conner, L., & Sanchez, D. (2000). Addressing spiritual and religious issues in counseling African Americans: Implications for counselor training and practice. *Counseling and Values, 45*, 28-38.

Creswell, J. W. (1994). *Research design: Qualitative and quantitative approaches.* Thousand Oaks, CA: Sage.

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

de Vos, A. S., & Fouche, C. B. (1998). General introduction to research design, data collection methods, and data analysis. In A. S. de Vos, *Research at Grassroots: A primer for the caring professions* (pp. 265-354). Pretoria: Van Schaik.

Denzin, N. K. (2005). Emancipatory discourses and the ethics and politics of interpretation. In N. K. Denzin, & Y. S. Lincoln, *The Sage handbook of qualitative research* (pp. 933-958). Thousand Oaks, CA: Sage.

Denzin, N. K., & Lincoln, Y. S. (1998). *The landscape of qualitative research: Theories and issues.* Thousand Oaks, CA: Sage.

Donald, A. (2001). The Wal-Marting of American psychiatry: An ethnography of psychiatric practice in the late 20th century. *Culture, Medicine and Psychiatry, 25*(4), 427-439.

Ebigbo, P. O. (1995). Harmony Restoration Therapy: An African Contribution to Psychotherapy. *International Federation for Psychotherapy (IFP) Conference, Lagos* (pp. 10-32). Enugu: Chumez Enterprises.

Ebigbo, P. (1997). Wawa technique in harmony restoration therapy: An African-psychiatric perspective. *Medikka: International Journal of the University of Nigeria Medical Students,* 5-11.

Ehrich, L. (2005). Revisiting phenomenology: its potential for management research. *Proceedings Challenges or organisations in global markets, British* (pp. 1-13). Oxford: Said Business School, Oxford University.

El-Islam, M. F. (1992). Transcultural aspects of Schizophrenia and ICD-10. *Curare. Journal of Medical Anthropology, 15*(4), 227-230.

Elliott, R., Fischer, C. T., & Rennie, D. L. (1999). Evolving guidelines for publication of qualitative research studies in psychology and related fields. *British Journal of Clinical Psychology, 38,* 215–229.

Englander, M. (2007). Persistent psychological meaning of early emotional memories. *Journal of Phenomenological Psychology, 38*(2), 181–216.

Englander, M. (2012). The interview: Data collection in descriptive phenomenological human scientific research. *Journal of Phenomenological Psychology, 43,* 13-35.

Erinosho, O. A. (1976). Lambo's model of psychiatric care. *Psychopathologie Africaine, 12*(1), 35-44.

Erinosho, L. (2007, November 15). The intellectual legacy of Professor Thomas Adeoye Lambo. Retrieved January 25, 2013, from Neuropsychiatric Hospital, Aro, Abeokuta: http://neuroaro.com/sites/default/files/downloadables/The%20intellectual%20Legacy%20of%20Professor%20Thomas%20Adeoye%20Lambo.pdf

Estroff, S. E. (1981). *Making it crazy: An ethnography of psychiatric clients in an American community.* Berkeley: University of California Press.

Eva-Marita, R. (2001). Water and healing - Experiences from the traditional healers in Ile-Ife, Nigeria. *Nordic Journal of African Studies, 10*(1), 41-65.

Fischer, C. T. (2006). Phenomenology, Bruno Klopfer, and individualized/collaborative assessment. *Journal of Personality Assessment, 87*, 229-233.

Flowers, P., Smith, J. A., Sheeran, P., & Beail, N. (1997). Health and romance: Understanding unprotected sex in relationships between gay men. *British Journal of Health Psychology*, *2*, 73–86.

Foucault, M. (1967). *Madness and Civilization : A History of Insanity in the Age of Reason.* London: Tavistock.

Frances, A. (2013, May 24). *Is Criticism of DSM-5 'Anti-psychiatry'?* Retrieved May 25, 2013, from Huffington Post Science: http://www.huffingtonpost.com/allen-frances/is-criticism-of-dsm-5-ant_b_3326980.html

Garrett, M. T., & Wilbur, M. P. (1999, October). Does the worm live in the ground? Reflections on Native American spirituality. *Journal of Multicultural Counseling and Development*, *27*(4), 193-206.

Genzuk, M. (1999). Tapping Into Community Funds of Knowledge. In L. A. Foundation, *Effective strategies for English Language acquisition: A curriculum guide for the development of teachers, grades kindergarten through eight.* Los Angeles: ARCO Foundation.

Gergen, K., & Gergen, M. (1988). Narrative and the self as relationship. *Advances in Experimental Social Psychology, 21*, 17-56.

Giorgi, A. (1985). *Phenomenology and psychological research.* Pittsburgh, Pennsylvania: Duquesne University Press.

Golafshani, N. (2003). Understanding reliability and validity in qualitative research. *The Qualitative Report*, *8*(4), 597-607.

Groenewald, T. (2004). A phenomenological research design illustrated. *International Journal of Qualitative Methods, 3*(1), 337-354.

Hammersley, M. (2000). Taking sides in social research. London: Routledge.

Hancock, B. (1998). *Trent Focus for research and development in primary health care: An introduction to qualitative research.* Trent Focus Group.

Haverkort, B., & Reijntjes, C. (n.d.). *Diversities of worldviews, knowledge communities and sciences and the challenges of its co-evolution.* Retrieved July 13, 2011, from CAPTURED: http://www.captured-edu.org/afbeeldingen/bertus-coen-edited2%20corrections-coen-bertus%20final.pdf

Hein, S. F., & Austin, W. J. (2001). Empirical and hermeneutic approaches to phenomenological research in psychology: a comparison. *Psychological Methods, 6*, 3-17.

Henning, E. (2004). *Finding your way in qualitative research.* Pretoria: Van Schaik Publishers.

Hopper, K., Jost, J., Hay, T., Welber, S., & Haugland, G. (1997). Homelessness, severe mental illness, and the institutional circuit. *Psychiatric Services, 48,* 659-665.

Hycner, R. H. (1999). Some guidelines for the phenomenological analysis of interview data. In A. Bryman & R. .G. Burgess (Eds.), *Qualitative research* (Vol. 3, pp. 143-164). London: Sage.

Irigoyen-Rascon, F. (1989). Psychiatric Disorders among the Tarahumara Indians of Northern Mexico. *Curare. Journal of Medical Anthropology*, 169-173.

Jegede, S. (2005). The notion of were in Yoruba conception of mental illness. *Nordic Journal of African Studies, 14*(1), 117-126.

Jilek-Aall, L., & Jilek, W. (1993). The Influence of Culture on Epilepsy in East Africa. *Curare. Journal of Medical Anthropology*, 141-144.

Kabir, M., Iliyasu, Z., Abubakar, I. S., & Aliyu, M. H. (2004). Perception and beliefs about mental illness among adults in Karfi village, northern Nigeria. *BMC International Health and Human Rights 2004, 4*(3), online.

Katz, J. H. (1985). The Sociopolitical Nature of Counseling. *The Counseling Psychologist, 13*, 615-623.

Kebede, M. (2004). *Africa's quest for a philosophy of decolonization.* Amsterdam: Rodopi.

Ketchum, T. S. (2010). Written out of history: A critical analysis of political science and policy studies. *Indigenous Policy Journal, 21*(3), 1-10.

Kirschner, S. R., & Lachicotte, W. S. (2001). Managing managed care: Habitus, hysteresis and the end(s) of psychotherapy. *Culture, Medicine and Psychiatry, 25*(4), 441-456.

Koolmatrie, J., & Williams, R. (2000). Unresolved grief and the removal of Indigenous Australian children. *Australian Psychologist, 35*(2), 158-166.

Krefting, L. (1991). Rigor in qualitative research: the assessment of trustworthiness. *The American Journal of Occupational Therapy, 45*, 214-222.

Kutchins, H., & Kirk, S. (1999). *Making Us Crazy. DSM: The Psychiatric Bible and the Creation of Mental Disorders.* London: Constable.

Ladele, O. (2009). Reconstructing identities through resistance in postcolonial women's writing: A reading of Ezeigbo's The Last of the Strong Ones. *Nebula, 6*(3), 70-84.

Lambo, T. A. (1954). *Observations on the role of cultural factors in paranoid psychosis among the Yoruba Tribe: a study in comparative psychiatry*. (Unpublished doctoral dissertation). University of Birmingham, Birmingham.

Lambo, T. A. (1955). The role of cultural factors in paranoid psychosis among the Yoruba tribe. *The British Journal of Psychiatry, 101*(423), 239-266.

Lambo, T. A. (1959). Mental health in Nigeria: Research and its technical problems. *World Mental Health, 11*, 131-138.

Lambo, T. A. (1960a). Further neuropsychiatric observations in Nigeria. *British Medical Journal*, 1696-1704.

Lambo, T. A. (1960b). The concept and practice of mental health in African cultures. *E. Afr. Med. J., 37*, 464-471.

Lambo, T. A. (1978). Psychotherapy in Africa. *Human Nature, 1*(3), 32-39.

Larkin, M., Watts, S., & Clifton, E. (2006). Giving voice and making sense in Interpretative Phenomenological Analysis. *Qualitative Research in Psychology, 3*(2), 102-120.

Lester, S. (1999). *An introduction to phenomenological research.* Taunton: Stan Lester Developments, Taunton.

Levingston, S. (2010, January 4). *Psychiatry's failed paradigm.* Retrieved May 20, 2013, from Washington Post: http://voices.washingtonpost.com/shortstack/2010/01/rcent_decades_have_seen_dramat.html

Louw, J. (2002). Psychology, history and society. *South African Journal of Psychology, 32*(1), 1-8.

Lovell, A. M., & Cohn, S. (1998). The elaboration of "choice" in a program for homeless persons labeled psychiatrically disabled. *Human Organization, 57*(1), 8-20.

Mair, M. (n.d., n.d. n.d.). *Kelly, Bannister and a story-telling psychology.* Retrieved June 10, 2011, from Oikos: http://www.oikos.org/mairstory.htm

Marshall, M. N. (1996). Sampling for qualitative research. *Family Practice, 13*(6), 522-525.

Minichiello, V., Aroni, R., Timewell, E., & Alexander, L. (1995). *In-depth interviewing.* Melbourne: Longman.

Moodley, J. (2009). *An Interpretive phenomenological analysis of the effects of burnout as experienced by volunteer lay counsellors (VLCs).* (Unpublished doctoral dissertation). University of Pretoria, Pretoria, South Africa.

Moran, D. (2000). *Introduction to Phenomenology.* London: Routledge.

Moustakas, C. (1994). *Phenomenological research methods.* Thousand Oaks: Sage.

Mouton, J. & Marais, H.C. (1990). *Basic concepts in the methodology of the social sciences* (Revised ed.). Pretoria, South Africa: Human Sciences Research Council.

Myers, L. (1985). Transpersonal psychology: The role of the Afrocentric paradigm. *Journal of Black Psychology, 12*(1), 31-42.

Myers, M. (2000). Qualitative research and the generalizability question: Standing firm with Proteus. *The Qualitative Report, 4*(3/4), Available: http://www.nova.edu/ssss/QR/QR4-3/myers.html.

Naidoo, A. V. (1996). Challenging the hegemony of Eurocentric psychology. *Journal of Community and Health Sciences, 2*(2), 9-16.

Neumann, W. L. (2000). *Social research methods: Qualitative and quantitative approaches* (4th ed.). USA: Pearson Education.

Nwoko, K. C. (2009). Traditional psychiatric healing in Igbo land, Southeastern Nigeria. *African Journal of History and Culture*, 36-43.

Nwoye, A. (2005). Memory healing processes and community intervention in grief work in Africa. *Australia and New Zealand Journal of family Therapy, 26*(3), 147-154.

Ocholla, D. (2007, September). Marginalized knowledge: An agenda for indigenous knowledge development and integration with other forms of knowledge. *International Review of Information Ethics*, 1-10.

Offiong, D. A. (1999). Traditional healers in the Nigerian health care delivery system and the debate over integrating traditional and scientific medicine. *Anthropological Quarterly, 72*(3), 118-130.

Omenya, G. (n. d., n. d. n. d.). *Social sciences and Black African resistance to academic slavery: Some reflections on the way forward.* Retrieved June 10, 2011, from Le Forum du Festival: www.leforumdufestival.com/texte3/doc8.pdf

Oshodi, J. (2004). *Back Then and Right Now in the History of Psychology: A History of Human Psychology in African Perspectives for the New Millennium.* Bloomington: AuthorHouse.

Owen, I. R. (1995). El construccionismo social y la teoria, practica e investigacion en psicoterapia: Un manifiesto psicologia fenomenologica. (trans I. Caro). *Boletin de Psicologia, 46*, 161-186.

Ovuga, E., Boardman, J., & Oluka, E. G. (1999). Traditional healers and mental illness in Uganda. *Psychiatric Bulletin, 23*, 276-279.

Oyebola, D. D. (1981). Professional associations, ethics and discipline among Yoruba traditional healers in Nigeria. *Social Science and Medicine* , 87-92.

Pearson, A. (2004). Recovery: Challenging the Paradigm (A Consumer Perspective). *Vicserve Conference* (pp. 1-11). Melbourne: Vicserve Conference.

Phillips, D. C. (1990). Subjectivity and objectivity: an objective inquiry. In E. Eisner, & A. Peshkin, *Qualitative inquiry in education: The continuing debate* (pp. 19-37). New York : Teachers College Press.

Polit, D., & Hungler, B. (2004). *Nursing Research, Principles and Methods.* Philadelphia: Lippincourt.

Porter, R. (1987). *A Social History of Madness: Stories of the Insane.* London: Weidenfeld and Nicolson.

Pringle, J., Drummond, J., McLafferty, E., & Hendry, C. (2011). Interpretative phenomenological analysis: a discussion and critique. *Nurse Researcher, 18*(3), 20-24.

Quimby, E. (2006). Ethnography's role in assisting mental health research and clinical practice. *Journal of Clinical Psychology, 62*(7), 859-879.

Raguram, R., Venkateswaran, A., Ramakrishna, J., & Weiss, M. G. (2002). Traditional community resources for mental health: a report of temple healing from India. *BMJ, 325*(38), online.

Reid, K., Flowers, P., & Larkin, M. (2005). Exploring lived experience. *The Psychologist, 18*(1), 20-23.

Reiners, G. (2012). Understanding the differences between Husserl's (descriptive) and Heidegger's (interpretive) phenomenological research. *J Nurs Care, 1*(5), 1-3.

Rinne, E.-M. (2001). Water and healing - experiences from the traditional healers in Ile-Ife, Nigeria. *Nordic Journal of African Studies, 10*(1), 41-65.

Rose, S. (1998). What is wrong with reductionist explanations of behaviour? In N. F. Symposium, *The Limits of Reductionism in Biology* (pp. 176-192). Chichester: Wiley.

Schmideberg, M. (1930). The Role of Psychotic Mechanisms in Cultural Development. *International Journal of Psychoanalysis, 11*, 387-418.

Setsiba, T. H. S. (2012). *Mourning rituals and practices in contemporary South African townships: a phenomenological study*. (Unpublished doctoral dissertation). University of Zululand, KwaZulu-Natal, South Africa.

Shek, D. T., & Lit, S.-W. (2002). Implications of social constructionism to counselling and social work. *Asian Journal of Counselling, 9*(1 & 2), 105-130.

Siegle, D. (2002, August 11). *Principles and Methods in Educational Research*. Retrieved December 2, 2012, from Qualitative Research: http://www.gifted.uconn.edu/siegle/research/qualitative/qualitativeinstructornotes.html

Smith, J. (2003). *Qualitative psychology - a practical guide to research methods.* London: Sage.

Smith, J. (2004). Reflecting on the development of interpretative phenomenological analysis and its contribution to qualitative research in psychology. *Qualitative Research in Psychology, 1*(1), 39-54.

Smith, J. A. (1996). Beyond the divide between cognition and discourse: using interpretative phenomenological analysis in health psychology. *Psychology and Health, 11*, 261-271.

Smith, J. A. (1997). Developing theory from case studies: self-reconstruction and the transition to motherhood. In N. Hayes, *Doing Qualitative Analysis in Psychology* (pp. 187-199). Hove: Psychology Press.

Smith, J. A. (1999). Towards a relational self: social engagement during pregnancy and psychological preparation for motherhood. *British Journal of Social Psychology, 38,* 409-426.

Smith, J. A., & Osborn, M. (2003). Interpretative phenomenological analysis. In J. A. Smith, *Qualitative Psychology: A Practical Guide to Methods* . London: Sage.

Smith, J. A., & Osborn, M. (2008). Interpretative phenomenological analysis. In J. Smith, & J. Smith (Ed.), *Qualitative psychology: a practical guide to research methods* (2nd ed., pp. 53-80). London: Sage.

Smith, J., Flowers, P., & Larkin, M. (2009). *Interpretative Phenomenological Analysis: Theory, Method and Research.* London: Sage.

Solberg, S. V., Ritsma, S., Davis, B. J., Tata, S. P., & Jolly, A. (1994, July). Asian-American students' severity of problems and willingness to seek help from university counseling centers: Role of previous counseling experience, gender, and ethnicity. *Journal of Counseling Psychology, 41*(3), 275-279.

Spiegelberg, H. (1975). *Doing phenomenology.* The Hague: Nijhoff.

Stewart, S. L. (2008). Promoting Indigenous mental health: Cultural perspectives on healing from Native counsellors in Canada. *International Journal of Health Promotion & Education, 46*(2), 12-19.

Storch, A. (1924). *The Primitive Archaic Forms of Inner Experiences and Thought in Schizophrenia.* New York: Nervous and Mental Disease Publishing Company.

Struthers, R., & Eschiti, V. (2005). Being healed by an indigenous traditional healer: sacred healing stories of Native Americans. Part II. *Complementary Therapies in Clinical Practice, 11*, 78-86.

Szasz, T. (1960). The myth of mental illness. *American Psychologist, 15*, 113-118.

Taye, O. R. (2009, September). Yoruba traditional medicine and the challenge of integration. *The Journal of Pan African Studies, 3*(3), 73-90.

Terre Blanche, M., Durrheim, K., & Painter, D. (2006). *Research in Practice: Applied methods for the social sciences.* Cape Town : University of Cape Town Press.

Touroni, E., & Coyle, A. (2002). Decision-making in planned lesbian parenting: An interpretative phenomenological analysis. *Journal of Community & Applied Social Psychology, 12*, 194-209.

Van der Riet, M., & Durrheim, K. (2006). Putting design into practice: writing and evaluating research proposals. In M. Terre Blanch, K. Durrheim, & D. Painter, *Research in practice. Applied methods for the social sciences* (pp. 80-111). Cape Town: UCT.

Waldron, I. (2010, May). The marginalization of African indigenous healing traditions within Western medicine: Reconciling ideological tensions and contradictions along the epistemological terrain. *Women's Health and Urban Life, 9*(1), 50-71.

Washington, K. (2010). Zulu traditional healing, Afrikan worldview and the practice of Ubuntu: Deep thought for Afrikan/Black psychology. *The Journal of Pan African Studies, 3*(8), 24-39.

Weinberg, D. (2008). The philosophical foundations of constructionist research. In J. A. Holstein, & J. F. Gubrium, *Handbook of constructionist research* (pp. 13-39). New York: The Guilford Press.

Wimpenny, P., & Gass, J. (2000). Interviewing in phenomenology and grounded theory: is there a difference? *Journal of Advanced Nursing, 31*(6), 1485-1492.

Wright, J., Webb, S., Montu, M., & Wainikesa, L. (2002). Conversations about indigenous counselling and psychotherapy. *Counselling, Psychotherapy, and Health, 3*(2), 115-126.

Yardley, L. (2000). Dilemmas in qualitative health research. *Psychology and Health, 15*, 215-228.

Yeh, C. J., Hunter, C. D., Madan-Bahel, A., Chiang, L., & Arora, A. K. (2004, September). Indigenous and interdependent perspectives of healing: implications for counseling and research. *Journal of Counseling and Development*, 410-419.

Zacharias, S. (2006, December). Mexican Curanderismo as ethnopsychotherapy: A qualitative study on treatment practices, effectiveness and mechanisms of change. *International Journal of Disability, Development and Education, 53*(4), 381–400.

APPENDIX A: TRANSCRIPT FOR INTERVIEW [P1] WITH INITIAL CODING AND SUBORDINATE THEMES

R	Researcher's Analysis of Transcripts	Transcription of Interviewer's Questions and Interviewee's Responses	Subordinate Themes
1.		Interviewer: I shall be asking you some questions, and then you can respond. First, I would like to know your name.	**Inherited healing practice** [R4] **Fluid and multiple specialization** [R8a] **Describing mental illness (explanation as narrative contextualization)** [R12a, R12b] **Understanding how mental illness emerges** [R14a, R14b, R16, R18] **Dependence on deified beings for healing** [R8b, R10a, R10b, R20] **Transferability of skill** [R22, R42a] **Diagnosis as divination** [R26a, R26b] **Non-formal intervention** [R28, R30] **The inadequacy of Euro-American mental illness paradigms** [R32a, R32b, R42b] **Non-formal practice and application of skill** [R34] **Memories of successful intervention**
2.		Interviewee: [Name given]	
3.		Interviewer: When did you start your practice, and were you trained by your father?	
4.	• Was trained by father	Interviewee: I have been practicing since 1973 before my father died in year 2003.	
5.		Interviewer: How old are you now?	
6.	• Tries with difficulty to recall age	Interviewee: You mean my age? 48 years.	
7.		Interviewer: Is it only the people with mental problems you treat or are there other types of issues you attend to?	
8.	• Does a lot of work attending to many types of problems • Is assured of success when prayers are offered	Interviewee: The work I do is much! I treat mentally challenged individuals, persons with stroke, those spiritually attacked by 'arrows', the barren, those processing their visa, as well as sick children. When I pray for these ones, they get okay afterwards.	
9.		Interviewer: Is it all kinds of mentally challenged persons that you have successfully treated?	
10.	• Believes that there are kinds of mental illnesses beyond his ability to heal • Going naked is crossing the point	Interviewee: No. If it is a person who has gone naked, then it's beyond our powers, but if the patient is yet to go naked then there is assurance of good health after prayer. There are some mentally challenged persons who	

	of no return	just sit in a particular place staring blankly; some can urinate on their body, others don't get to sleep both night and day. Some are of higher powers and these types of persons don't have good intentions – so they go paper-picking or running wildly all over the place.	[R36] **Lack of standardized healer-client Relationships** [R40]
11.		Interviewer: What does it mean to be 'mad'?	
12.	• Explains 'mental illness' situationally (laughing to oneself, walking aimlessly, and ignorance about nudity) • Thinks 'wèrè' involves obliviousness to one's actions	Interviewee: I would say a person is mad (wèrè) if he talks to himself and laughs all by himself, or he/she walks aimlessly from time to time, or he/she does not realize that he/she is naked.	
13.		Interviewer: When such a person is brought here, how do you go about understanding its cause or origins?	
14.	• Emphasizes mystery of understanding 'mental illness' • Presumes diabolical influence, drug substance misuse and forces beyond our control are involved	Interviewee: When the person is brought here I would detect if it is a diabolical situation and if nemesis caught up with the person or if the person is under the influence of drugs (igbó). There are also some cases in which some persons encounter their troubles late at night.	
15.		Interviewer: Which class of mentally challenged people do you attend to the most?	
16.	• Substance misuse is most frequent cause	Interviewee: Those under the strong influence of drugs.	
17.		Interviewer: Persons trained and educated in universities and Western-type settings don't believe in 'nemeses' or 'invisible life forces'	

		(ayé) as a cause for these troubles.	
18.	• There are forces beyond our control – even when we don't believe it	Interviewee: That is true, but it does exist.	
19.		Interviewer: How do you know what to use to appease these forces for treating your patients?	
20.	• Is assured of intervention of invisible, deified entities and forces	Interviewee: We ask the gods what to use to appease them and they listen.	
21.		Interviewer: Can you teach anyone your skills?	
22.	• Believes healing skills are transferable	Interviewee: We have had a lot of students in this field. At least seven (7) of them graduated from my tutelage.	
23.		Interviewer: How would you know a person that will be good as an herbalist?	
24.	• Ifá decides a good herbalist	Interviewee: I consult Ifá (a chief Yoruba deity).	
25.		Interviewer: What is the procedure for admitting your attendees?	
26.	• Ifá ordains healing • Consulting Ifá is at the heart of intervention	Interviewee: When I meet a client, I consult with Ifá to know if our powers to heal are equal to the task. If Ifá listens, Ifá tells me what to do and what to buy (for the healing ritual).	
27.		Interviewer: How many persons have you taken care of so far?	
28.	• Takes care of clients informally and in undocumented ways	Interviewee: I have lost count!	
29.		Interviewer: Do you accommodate your attendees anywhere?	

30.	• Accommodates clients in home or in adjoining quarters for safety	Interviewee: Yes.	
31.		Interviewer: Do you understand the treatment modalities of modern psychotherapists and do you employ them in approaching your attendees?	
32.	• Modern psychotherapy is inadequate • Uses herbs to manage problematic clients	Interviewee: Yes, sometimes we give them tablets or herbal concoctions so they can sleep off. Once they sleep, we know their problem is manageable.	
33.		Interviewer: How do you know the herbals you will use for treatment?	
34.	• Does not depend on forma systems of learning and training, but imbibed skills, memory and sacred consultation	Interviewee: I simply know when the time is right; I was taught how to know.	
35.		Interviewer: Can you recount a notably challenging experience with treating your clients that you have had since you started to practice?	
36.	• Fondly recalls being able to manage strange conditions of a woman successfully	Interviewee: A person was brought from Winners' Church. She kept shouting for three days; on the fourth day we chained her and gave her herbs to drink. Immediately her agitation was contained and all the troubles seized.	
37.		Interviewer: What is your maximum admission period for your clients?	
38.		Interviewee: 3 months	
39.		Interviewer: Do successfully healed persons come back afterwards, and if they do, why?	

40.	• Maintains healing roles and convivial relationships with former clients	Interviewee: Yes, they come back from time to time to get herbs.	
41.		Interviewer: What would you like to tell modern 'educated' psychotherapists about the influence of ‘invisible life forces’ (ayé) on human mental health?	
42.	• Takes considerable time to master our knowledge base • We know things that modern clinicians do not know	Interviewee: Well they should come and learn this job for 3 years!	

APPENDIX B: TRANSCRIPT FOR INTERVIEW [P2] WITH INITIAL CODING AND SUBORDINATE THEMES

R	Researcher's Analysis of Transcripts	Transcription of Interviewer's Questions and Interviewee's Responses	Subordinate Themes
1.		Interviewer: Before we begin, we're going to record our conversation with this device. We only want to record what we are saying. Is this alright with you?	**Inherited healing practice** [R10] **Awareness of heritage, competence and self-identity as healer** [R12, R14a, R16a, R28, R30, R32, R38a, R38c, R40b, R54d, R62] **Narrative, non-reductionistic differentiation of manifestations of mental illnesses** [R14b, R14c, R16b, R20, R24a, R24b, R36, R40c, R52a] **Non-ordinariness of objects and everyday life** [R18, R54a, R54b, R54c] **Assemblage of competencies and skill-sets** [R38b, R40a] **Non-pathologization of problems of living** [R50b] **Mental illness as injustice or perversion of sacred order and place** [R52b, R58b, R60c,] **Malicious agency and intentionality (ayé)** [R52c, R52d, R52e]
2.		Interviewee: Just tell me whatever you want.	
3.		Interviewer: Thank you, sir. We would like to know you. He'll (the researcher) be writing the things I say…the questions I ask you. He has questions he's going to ask you. Okay…what is your name?	
4.		Interviewee: [names given]… alias 'African Whiteman' (laughter).	
5.		Interviewer: How old are you sir?	
6.		Interviewee: I was born in 1976	
7.		Interviewer: Okay sir, were you born here?	
8.		Interviewee: No, my hometown is Oniro. I came here to practice shamanism.	
9.		Interviewer: Where?	
10.	• Recalls influence of father	Interviewee: I was born in Oniro. [My father]…he was the first rich person in Ibogia, in all these parts, in the whole of Ogun state, even Nigeria. Chief Bolarinwa Aduroro?	
11.		Interviewer: Okay sir, so, can you tell us a little about your work?	
12.	• Identifying oneself as a healer	Interviewee: My work…I do the work of a	

		healer; I take care of people.	**Non-formal learning of healer** [R56] **Emphasis on bodily, embodied understandings of mental illness** [R42, R50a] **The inadequacy of Euro-American mental illness paradigms** [R44] **The agency and influence of sacred entities in mental health and wellness** [R50c] **Partnership with the paranormal in detecting and evoking healing** [R58a, R60a, R60b, R68, R70]
13.		Interviewer: Okay sir, so anyone can be brought to your place?	
14.	• Is confident about healing abilities • Identifies 8 types of mental illness • Uses descriptive, non-standardized, fluid labels to create 'soft' categories or typology	Interviewee: There's no shamanic work I don't know, regarding people getting well. If you want someone to get pregnant, I know about it. If someone runs mad and you want us to take care of him, I know about it. Although, there are 8 types of madness we can observe. If we want to say it well, there are over 201. There's the 'madness of the wind'. There is the one who goes out and gets blown upon by the wind (atégun). The wind touches him; he begins to [behave in a particular way]. He is incoherent in his speech, and speaks to no one in particular. That's the one of the wind (wèrè atégun). Then there's the madness of the breeze, wherein the breeze was intentionally sent to him. They've sent 'something' to him. They've sent something to him. That's a mad person.	
15.		Interviewer: How will such a person behave?	
16.	• Re-enacting experiences of mentally challenged people • Identifying different manifestations of mental illness	Interviewee: That one too wants to run mad. Abugije…that one, they use clothes to cause harm to that one. He'll be shouting. His eyes will be [describes it]! They use clothes to do that one. Then there's one whose hair is taken away – that is the one that we see walking around.	
17.		Interviewer: Who? What is taken?	
18.	• Attaches significance to, and	Interviewee: His hair. We mustn't joke	

	implicates, everyday objects in influencing mental illness	around with it.	
19.		Interviewer: So, there's a madness that comes because the 'wind' blows on a person. And there is another, to whom some kind of invisible force was directed. And then there is one whose clothes afflict him and cause the madness.	
20.	• Madness of 'wind' (wèrè atégùn); madness of 'breeze' (wèrè aféfé); madness through exchanged clothes; misuse of psychoactive substances; misplaced hair; enchanted names; provoked by curses (asínwín); through dreams (abisínwín) [lack of reductionistic differentiation]	Interviewee: Yes, that his clothes were taken. There's also a type where the person himself is responsible for his own condition, either by smoking 'weed', or by smoking cigarettes. Once such a person smokes, and they put even a strand of hair inside, he'll run mad.	
21.		Interviewer: That's five, sir.	
22.		Interviewee: Five? Good. There's one where they take a person's name and his mother's name. They do terrible things with the names.	
23.		Interviewer: Ok sir, that's six.	
24.	• Uses stories (descriptive/narrative labels, not explanatory, reductionistic labels) to delineate/distinguish between fluid 'types' of mental illness • Cascading categories	Interviewee: That's six. There's one that is not good at all. That's the one they call 'asínwín'. This is done with a curse. They go to prepare curses and they curse the person. They will call his/her name and curse the person. Even the person whose name is not known…like how you are now, if someone should insult you and you have some powers, you could say "Ehen, you slapped me, you beat me", and then you point your hand, you	

		point with shamanic powers and then turn the person mad with your powers.	
25.		Interviewer: Now the seventh one.	
26.		Interviewee: The seventh one. This one hits a person from the dream, or a woman that just gave birth. This one is called 'abisínwín'. It hits someone from the dream. Yes, from the dream. Or maybe a woman gives birth and sees the blood and runs mad. That is called 'abisínwín'.	
27.		Interviewer: How did you start this work? Did your father teach you?	
28.	• Tries to establish shamanic legitimacy and authenticity by tracing heritage and narrating life biography	Interviewee: This work, it's my father's work. It was also my father's father's [paternal grandfather] work. It was also my mother's father's [maternal grandfather] work. It was also my mother's mother's father's [mother's maternal grandfather] work. My mother's father's father [mother's paternal grandfather] and my father's father [paternal grandfather] were friends. As they were friends, they helped each other and taught each other charms, taught each other important works. They taught one another and gave each other powers. My mother's father's father then told his child that "the child you give birth to, it is my friend I want to give her to." That was how my mother was given to my father. My father married 11 wives but out of all his children, I am the most skilled.	
29.		Interviewer: Your father married 11 wives?	

30.	• Affirming biography and unique background	Interviewee: Yes, 11 wives.	
31.		Interviewer: But, it is only your mother's children that know the work.	
32.	• Amplifying self-significance and pride of place	Interviewee: …that know the work best. I was the first to know the work best and became the best.	
33.		Interviewer: When did you start?	
34.		Interviewee: When I started?	
35.		Interviewer: Yes sir.	
36.	• Again, there's some difficulty with numbers and quantity	Interviewee: How long has it been since I started this work now? 20 something years? 27 years. And I still have a client who has been working for me all these years till now.	
37.		Interviewer: You've been working with this person since?	
38.	• Insisting on authenticity as attested to by positive feedback from clientele • Announcing multiple skill-sets and expertise in healing bodily and mental ailments • Testifying to his unique powers by recalling a narrative of a 'close shave'	Interviewee: Toh! We've been together for 27 years and he still hasn't left. If someone wants to collect a contract from a company and they don't give him, if you bring him here, they will give him. Do you understand? I know a lot of works. There's a parasite they call 'jedojedo', they call it 'jekidinrin'. It eats the heart' it's a parasite. We treat it. The people that say they have AIDS, we treat it. They contact a disease, but there's nothing like AIDS anymore. It's only 'iro' that doesn't have a drug and yet there's even a drug for it. We use 'magun' for him, we use "ero" and take care of him. As I am now, seated in front of you, I contracted "Iro" four times before I got married. I went to a town	

		where a female friend hosted me. I didn't know that it was a Shaman's wife I was given to sleep with. I said "This one has given birth already" She said I should sleep with her (unclear). I then tried to (unclear). Ah, I said "I have contracted something". I said I'll get home. From (unclear) I got home, I didn't tell my children. I then got into the house I go into, I will show you the house soon. (Unclear) I excreted and declared myself well. I didn't tell anyone. After one year, I then told my wives and my children. It was when I saw that I counldn't see any of the symptoms of that thing on my body that I said "Ehen". (Unclear) my enemy o, she wants to kill me o (unclear). Magun is like having a farm. A woman is the farm. The farmer can do anything he wants with his farm, the thief must accept anything he sees.	
39.		Interviewer: Yes sir. He wants to ask further questions now about how you understand mental illness and detect it.	
40.	• Refers to inexhaustibleness of knowledge base • Attempts to demonstrate manipulative powers presently • Presents no strict definitions but relates to the phenomenon in terms of how it manifests and his ability to manage it or instigate it	Interviewee: About how I see a mad person? We can't say it all, it's my work. I told him the other day. We use rams to look at it. Anyone whose madness seems to be becoming too much, we use a ram to observe it. We use a mirror to look at his face, when we do this, he'll become well. We have an 'epe' that I use to look at him. [Addressing his assistant] Open that place and bring that 'epe' for me. It's in that small red-yellow bag.	

		The small yellow bag. [Places powdery substance from the bag close to his mouth]If I want to, I could make the two of you slap each other, just so we see together. Let's try it, so you can know you met someone notable.	
41.		Interviewer: Okay, he wants to ask some questions about, em, what is your definition of a mad person?	
42.	• Exclaims about the obviousness of the phenomenon	Interviewee: You don't know who a mad person is? Mental problem, isn't it?	
43.	•	Interviewer: Yes sir.	
44.	• Contrasts understanding with Eurocentric ideas about mental illness	Interviewee: That's what the White people call madness. God will not let you run mad.	
45.		Interviewer: If they bring someone to you now, what are the things that the person will be doing that allows you to know what is wrong with such a person?	
46.		Interviewee: The person they bring to me? You see, there are different types of madness, we can't exhaustively discuss it.	
47.		Interviewer: Okay sir.	
48.		Interviewee: What did I tell you?	
49.		Interviewer: You said we can't finish discussing it.	
50.	• Narrates, acts out, and attempts to demonstrate what it means to be mad • There is a palpable lack of	Interviewee: You can't talk exhaustively about madness. Secondly, if a person's hands are tied to the back, what has he become? Hasn't he become mad? If he is handcuffed, what has he become? Some people will wear clothes (unclear) what has he become? If you	

	conceptualization of ‘problems of living’ as mental illnesses • Is effusive with prayers and entreats the ‘divine’ for blessings	are looking at a mad man, if you are looking at him well, he will be doing this [blows and spits violently into the air]. It's the poisons in him that he is spitting out. He will be spitting out the poisons. We have what we can do to mad people to make them sleep immediately. If you want to turn it into a western drug and you’re serious about it, we’ll discuss and talk about payments and think about it. This is what we use to talk to mad people [pulls out an object]. Let’s play. [Speaking to his assistant] You stand. Take, ask them [the researchers] to be hitting themselves till tomorrow. This one is used to pray to God for the mad person to get well. This one is to make one’s life how one wants it. How one what? How one wants it. If someone cheats you, you swear against him and his life spoils. That is what they call a charm. Everything here is powerful [pointing at charms and objects in front of him]. As you are looking at it, he could ask you to slap yourselves, and surely you will slap yourselves! Although, if we do that to you, we’ll become evil shamans in your eyes and we are not evil. If you hurriedly bring a mad person here now, I’ll use something to first calm him down because, there was a day I sent my apprentices to go and bring a mad man, but another shaman had already gone to accept the job behind our backs. When he went to accept the job, he died. My	

		apprentices didn't know that the mad person had hid a knife. They then got there and struggled to hold the mad person down. As they pulled the mad person's leg forward and he fell down, you know his hand had become free from his side. The knife he pulled out, he stuck it into my apprentice's belly. The treatment of mad people is a difficult job. He stabbed him in the belly. I'm not treating again (laughter). God won't let us all run mad. We will build the houses we want. We will drive the cars we want. (Unclear) God wants to do a good new year for us. You won't see sadness neither will I, nor my children nor my wife nor you, nor your children nor your wives nor your siblings (unclear) in Jesus' name. (Islamic prayers)	
51.		Interviewer: Okay, he's asking that if someone tells you that someone else is mad, what will you say happened to the mad person? How do you distinguish between sanity and insanity? What is the meaning of madness?	
52.	• Attempts a definition with some difficulty, then gives up and employs narrative labels • Identifies phenomenon as a perversion of a sacred order • Links the phenomenon with malicious agency beyond our control (ayé) • Sees phenomenon as diabolical and	Interviewee: You see, madness is something that is not good. Madness is a recreation. Say it in English. A recreation, you know God made us well. However, a mad person is defined through ritual or enemy powers in use, satanic powers. It's no longer the person. If he was someone that couldn't eat one wrap of food, when he becomes mad, he can eat 20 wraps. His bones will double in size, his	

	intentional • Sees phenomenon as very often self-inflicted	eyesight will double. His whole body will be unexplainably strong. If you could hold him before, you wouldn't be able to afterwards because his bones would have been strengthened. Sometimes, they put things in people's foods like poison. A friend can give a person, a mother can give her child, a father can give his child to eat. It's only God that wants us to do well, people don't want us to. The mouths that we feed are the ones that bite us. Yet you are the one working to feed him! Do you know what that means? For example, you own a company and you hire someone to work for you, you are the one paying him and his family is enjoying, his parents are eating. You then offend him in a way that shouldn't be such a big deal but then he takes it personal and spoils something in your business. He has spoilt something good. What can cause madness? There are a lot of things that can cause madness. You see we humans in particular…with these our mouths, we must not say things that are not good to each other. God said we are children of authority; he said we will speak with authority and he will answer us and our questions with authority. That is why women…if your wife should give birth and is joking around with curses on your child and you tell her to stop and she refuses, chase her away. This is because she is spoiling the child's future; God will not spoil our futures.	

		That is what is putting many mothers in trouble now. They'll say "You this child, you this wicked child, they will not enjoy you", and they themselves will not enjoy the child and the child's life will not be good; they will suffer together. My wife must not joke around with curses on my children. I don't do this with my children; neither do I do so with my siblings. If at all I am really offended, I will call him "bastard child from heaven!" Who is a "bastard child from heaven"? A child that I am clearly his father that clearly has a part of me in him…? Ok, a woman that gives birth for us that is swearing for the child, you know it is not good. A father that does the same, is that good? It is not good. We too that are parents cause a lot of troublesome things. Sometimes, when your child gives you 5 Naira, you must not tell anyone that he/she gave you money because people don't want you to eat well except sorrow; God will not let us eat sorrow. Many parents bring challenges upon their children. Some people, once the child is abroad, they'll say the child is now rich. Some people will be abroad for many years and still be unable to build the type of house we're sitting in now, till they die. With the child abroad, the relatives will now start calling and asking for money, if he doesn't answer, they'll turn him mad and he'll be sent home. He'll start walking around and become nonsense. That	

		is why they say relatives…the whites say something: they say that one's children are family, after that, there is no family, and it is true. God won't let us give birth to an enemy of a child, but for a child to kill his father is hard. Except if the woman brings the pregnancy from somewhere else and the child is a true bastard. If a woman is in her husband's house and she is under her husband and she has bastard children and is then swearing that if she does so and so, her life should become so and so, do you know that the children will suffer curses?	
53.		Interviewer: So it's people, the things that they say and do to one another and those that have been blown by wind and those that have taken too many drugs.	
54.	• The world is charged with meaning and hidden dimensions • Even the most minuscule items have a proper place and sacred meaning • Everything is like a 'tuning fork'…imbued with more than what meets the eye • Questions the necessity of the conversation and seeks to legitimize his narrative by a demonstration of his powers	Interviewee: Yes, it's not simply if it's too many drugs, it is if there is hair in the drugs. Hair, if they put it in the drugs, if he smokes it, he'll run mad. You know what, all what we have said, it's too much. Go and look for one person that is mad and bring him here. I won't collect a single 'kobo' from you, I'll treat him myself. Only be sure that he is mad and bring him, and I'll treat him myself. In front of him, if I give him (the mad person) before his (the researcher) eyes and he sees how we treat him, he'll know better about it. This explanation is like 'theory and objective'. I don't understand English that well, I'm not educated; I only know a little.	

		What is theory? What is objective? Practical! Ehen! What is practical?	
55.		Interviewer: The one you do with your hands.	
56.	• Affirms significance of his non-formal education	Interviewee: That's the farm I went to and got 'educated' in!	
57.	•	Interviewer: So if (the researcher) brings someone, you can tell him the rudiments of your practice and those things you do.	
58.	• Attests to hidden, esoteric dimensions of his practice • Asserts injustice of agency in mental illness	Interviewee: You see, what we see is secret; I don't know how to say it in English. It is secret. Sometimes, if it is the father that turned the child mad, if you tell people, they will kill themselves. You are the one that will know within yourself.	
59.	•	Interviewer: How do you know what is wrong with them?	
60.	• Diagnosis is instigated by connection to sacred entities • Seeing is extraneous to the shaman…healing is partnership between realms • Asserts retributive elements of practice (including onset and treatment of phenomenon) – the shaman is more than a 'healer', he is a judge, dispensing with justice; in this sense, the metaphor of mental '*illness'* is only a dimension of this phenomenon	Interviewee: Do you know that there is a curtain in my 'Ifá' place over there? That curtain that you are looking at works like a television. Once I touch the person's face and cover it with my hand and do like so and so, call it how we want to call it, it'll light up for us and we'll see. That is what a shaman uses to eat. If someone runs mad and we see it, if we want, we can send the madness back to who it came from. We must send it back. Back to sender! Back to sender!	
61.		Interviewer: If someone comes, and has been blown upon by this mysterious wind energy, how will you know? Or…	

62.	• Seeks to end conversation with researchers; wants to demonstrate efficacy	Interviewee: We can't say, that's why I said go and bring a mad person first. The talk is too much. Even the one of the wind, it's not really madness…the person will only be misbehaving.	
63.		Interviewer: That's it.	
64.		Interviewee: What I want to teach you is what I'm teaching you.	
65.		Interviewer: We can't know it all; we only want to understand how you practice your art.	
66.		Interviewee: I'm only playing with you too [laughs].	
67.		Interviewer: So the person they bring, you'll know what is wrong by how the person behaves.	
68.	• Emphasizes utility of 'lesser' sacred entities	Interviewee: You know what day you should come if you want to enjoy my talk? Wednesday or Saturday. If you want to come, call me before you do. When I'm free. Wednesday, we'll talk till we're satisfied, you too will bring money along and you'll buy good alcohol. Do you understand? We'll drink good alcohol and celebrate, no visitor will disturb us. We'll both explain. He will also be able to calm down and write what he wants to write. My younger brother, Ade, will be with us and will help explain better. There are also some books that I will bring out too, because there are some things that are better understood this way, do you understand? Deities…god doesn't want us to worship deities, do you understand? The	

		reason god doesn't want us to worship deities is…for example, if you see your wife's bastard, you'll kill it, right? You know, god is supreme. If you study my environment, you won't see any deity I'm worshipping. Or have you seen? That one on the floor there, we give it palm oil for our charms to work.	
69.		Interviewer: But if we bring someone, is it in there that you will treat the person…	
70.	• Distinguishes between work place where divination occurs and quarters where clients are accommodated	Interviewee: No, I won't put him there. I treat them here, not there. I don't take mad people into the power house of my work. I'll go there myself and ask and come back. Later on, it's in this same place I'll reveal things.	

APPENDIX C: TRANSCRIPT FOR INTERVIEW [P3] WITH INITIAL CODING AND SUBORDINATE THEMES

R	Researcher's Analysis of Transcripts	Transcription of Interviewer's Questions and Interviewee's Responses	Subordinate Themes
1.		Interviewer: We would like to ask you some questions but first of all may we know your name?	**Inherited healing practice** [R12, R64] **Awareness of heritage, competence and self-identity as healer** [R8, R10] **Mental illness as shame** [R72] **Narrative, non-reductionistic understandings of mental illnesses** [R20b, R30a, R34a, R34b, R34c, R40, R42a, R42b, R48b] **Story-based typology and aetiology** [R16a, R38a, R38b, R44, R46] **Assemblage of competencies and skill-sets** [R28a] **Non-formal relationships with clients** [R30b] **The agency and influence of sacred entities in mental health and wellness** [R32] **Describing mental illness (explanation as narrative contextualization)** [R16b,
2.		Interviewee: My name is [names given].	
3.		Interviewer: Is this were you were born or did you migrate from somewhere to this place?	
4.		Interviewee: This is where I was born and bred; I'm a thoroughbred indigene of this land.	
5.		Interviewer: How old are you?	
6.		Interviewee: I would say 46 years old.	
7.		Interviewer: Alright. When did you start your practice?	
8.	• Gives sense of heritage in practice	Interviewee: My father had been doing this job for a very long time, while I was being raised. After my father died I took over the practice.	
9.		Interviewer: Can you recall the year you started this job?	
10.	• Affirms a generational link in practice	Interviewee: Of course, I know the year I started this job; it was in November 2011 because my father died on the 14th of November, 2011. Before his demise I had been assisting him with the job. Now that he's dead I have taken after him.	
11.		Interviewer: What exactly do you do? Do you treat 'mad' people generically or there are particular cases that are brought here?	

12.	• Links with extended family for support	Interviewee: What really happens is that we have a man that is into this kind of job, who happens to be my father's elder brother. That's where we were trained on this particular kind of healing. Once we realize that a case is too severe, we approach my uncle.	R18b, R24] **How mental illness emerges** [R18a, R20a, R50] **Awareness of heritage, experience, competence and self-identity as healer** [R46b, R76b] **Memories of successful intervention** [R66, R70] **Healing as justice or retribution** [R26b, R60] ***Ayé* and the Non-ordinariness of objects and everyday life** [R56] **The inadequacy or incommensurability of Euro-American mental illness paradigms** [R36b, R74, R76, R78a, R78b, R78c, R80] **Diagnosis and intervention procedures** [R14, R20c, R26a, R30c, R36a, R48a, R54, R58] **Herbal administration as form of treatment** [R52] **Duration of intervention and recovery** [R28b, R68]
13.		Interviewer: Are such cases brought here first?	
14.	• Describes generic ways mental illness is detected (asking questions, observing behaviour, listening to answers, drawing on conclusions)	Interviewee: Yes, they are being brought here first; we ask questions from whoever brought them about the situation of the person. Some answers are provided. Then we question the individual himself and observe his behaviour. By the time we see the way he is behaving we know he is mad.	
15.		Interviewer: Is it only 'mad' people they bring here or are you into other things?	
16.	• Distinguishes between different maladies that are attended to • Identifies 'inógíje' as a form of madness	Interviewee: We deal with issues like madness, sickness, rheumatism…and there are some cases that are different from madness: the problem is called 'inógíje'. It manifests in form of madness but it is different from madness.	
17.		Interviewer: What causes that form of behaviour?	
18.	• Traces onset of *inógíje* madness to retributive agency or aggrieved party • Uses 'brain' to reify bodily centre of psychological disturbance	Interviewee: This charm is prepared by other people and often planted in the farm for those that come to the farm to steal crops. Once an individual goes to that farm to steal crops the individual's 'brain' will be altered, and he/she will start misbehaving in the way they	

		want them to according to the charm specification.	
19.		Interviewer: Those that are brought to you, what are the causes of their conditions?	
20.	• Some 'sources' of this abnormal behaviour are 'family attacks', 'curses/incantation', 'getting beaten with a charmed cane' • Uses allegorical accounts to establish definitions of different mental disorders (non-reductionistic explanations) • Detects problems by initial observation and client reaction to herbal concoction	Interviewee: Some of these behaviours are from family 'attacks'; some of them are due to crimes they have committed outside the walls of their families – thus invoking the behaviour upon themselves; others are due to curses and incantation inflicted upon them because of an offence committed to someone – they would say to such a person: "As you are going you would be turn to 'wèrè'; keep walking about pointlessly!" And then others offend people and are been beaten with a charmed cane. By the time they bring them to us and we observe his behaviour, we bring out a special cane with charm on it and whip him with it for his body to calm down. Once his body calms down, we already know that he is a mad being; we then administer to him 'agbó' [a liquid herbal concoction].	
21.		Interviewer: When you whip them, are you able to know what particular type of madness they suffer from?	
22.		Interviewee: Yes, we will know after beating them with the charmed cane, we also have some other ones that come in form of a strange sickness. In these cases, the people will all of a sudden start feeling feverish heat all around their body (both internally and externally) and then all of a sudden they	

		would stand up from where they were seated among their peers and start running – leaving everyone puzzled!	
23.		Interviewer: What causes this phenomenon?	
24.	• ‘Òtútù itá’ or ‘ìgbonná’ is a related condition of mental disturbance – strange sickness, internal heat, bizarre behaviour	Interviewee: This is called òtútù itá, also known as ‘ìgbonná’ (fever).	
25.		Interviewer: How many persons are brought to you in, say, a month? Do you know?	
26.	• Successful intervention is based on client’s provision of ritual materials • Emphasizes healer’s vicarious roles and non-commercial functions as healers…highlights retributive effects against healer if one ‘collects money’ from a client	Interviewee: What happens is that about 10 persons could be brought here, but after negotiating with them some of them might not be able to afford our fee – and thus want to take their case back home. Sometimes we have to turn them back. In this work we do, we are not allowed to collect money for our practices and consultation; we only request money to purchase the materials we would use. When you look at a ‘wèrè’, who has started to recover, you must not collect money. If one collects money, one would give birth to a mad person.	
27.		Interviewer: What is the most popular or frequent type of problems that people bring?	
28.	• Asserts multiple skills and expertise and low frequency of mental cases • Severe cases take on extensive periods for recovery	Interviewee: There is no kind of ailment brought to us that we do not address; there is no form of sickness that we can't work on. We work according to the job we have been given. But in this very year that we are in we've not had any form of ‘mental’ cases apart from those that their businesses are not	

		prospering well, or those that need promotion or those not feeling too well. But as at last year we treated 12 patients – which were manageable; but for cases that have gotten very severe (over 4 or 5 years – who has 'entered the market'), when we have treated for some time, we take them to my uncle's place because we have a house there where we tie them down and begin to treat them for a long period of time. The reason is that such a case has already gotten out of hand and it needs close monitoring, proper attention and care. It will take us about a year or two to cure such a person.	
29.		Interviewer: What is your perspective about this mental illness? What do you think are the causes and how do you alleviate them?	
30.	• Conception of mental illness is organic, visceral, engaged, and grounded in life-world and stories – in contrast to the explanatory, reductionistic, theory-laden, impersonal professionalism of modern psychotherapeutic practice • [observation] Maintains cordial correspondence with clientele • Intervention commences with observation, administration of *agbó* if demanded, 'caning', divining inquiries into sources of	Interviewee: [receives a phone call from another client] The person who just called me now was also not feeling well. He had stroke. He was at a party and then fell. After we started taking care of him, he grew better. He is doing well and can talk – and we know that people that usually have stroke have 'twisted tongue'. About people who are mad, when they are brought here, if the case is fresh – and they bring him in – we would look at him for some time. If it is the sort of case that needs the cane, we will give him the cane. After we whip him, we observe him again, and then give him agbó [liquid herbal concoction] – the one we want to give him	

	enchantment, and attempts to restore order with aggrieved parties, retaliatory acts in case enchantment is not withdrawn, and sustaining wellness	initially. If he sleeps with this initial drink, his case is still normal – not severe. His case won't take up to, let's say, 3 or 4 months, for a total cure. This means the charm or ailment as the case may be is still fresh on his body; this charm deprives an individual from not sleeping, because once the charm starts working the individual won't be able to get some sleep, he would be roaming round the house saying "give me something", while everyone else is asleep. If anyone is awake and observant about this change in behaviour, the person would bring him to us so as to know the nature of the sickness; that is when we will now administer the cane and the liquid drink for his body to calm down. If we now want to know the person that is responsible for is ailment we will check it to know if it is a woman or man that is responsible and if it is a man or a woman we will tell the family of the patient to inquire on who he/she has offended either within or outside. Perhaps the individual might have had a misunderstanding with somebody or may be somebody was to inherit the property of the father and decided to place madness on the individual so as not to remember the property. The charm (madness) is usually done for people that have many farm lands or when they realise that a family has more property than the other they would look for a way to scatter the family by invoking	

		madness on the individual so as to gain control over the property. For instance, my father had so many properties before he died. If there was a way that my family members could have gotten me mad they would but they did not – maybe because they know what I can do. So by the time we know who is responsible for the madness we would ask for what he/she wants, if it is for us to send back the madness, the person will go mad because he/she is the one responsible for the curse, and since she did not do it in the presence of somebody when invoking the curse it will be difficult if she tries to find solution to her new circumstance because she won't be able to remember what exactly was the reason why she did what she did in the first place. Thus she will carry this madness for life in order for the other person to be well and stay well.	
31.		Interviewer: So, in your opinion, it's people who usually 'bring' these conditions upon other people?	
32.	• 'Mental illness' is agent-based, intentional, deliberate, and involved – not accidental and impersonal	Interviewee: Yes, madness does not come upon people anyhow; it is somebody that does this to another person.	
33.		Interviewer: What will you call a person that is 'mad'? Rather, what we mean to ask is: what is the meaning of mental illness? What are the things you see that signify that this phenomenon is present?	

34.	• Difficulties understanding researcher's questions (inquiry is couched in the universal, while responses are framed in the particular) • 'Madness' is conceptualized descriptively; explanatory frameworks are not probing, but 'wide' – storied, figurative • Deviation from nuanced relationships is how to detect the onset of 'mental illness'	Interviewee: A person that is mad is mad – there's no special name, but for us to know how it comes about… let's take for instance the present moment. You see the way we are having a conversation? Each of us responding to each other's questions? You ask, and I give an answer. If it were to be a mad person and you tell him to remove his clothes, he won't remove his clothes. He would rather be doing something totally different from what you are telling him to do. He could suddenly begin scattering things or vandalizing things around him when all you said was remove your cloth. He doesn't hear anything you say anymore. That is how you will know that something is wrong with this person.	
35.		Interviewer: We understand that a person could be afflicted in this manner this way – but only briefly…perhaps even for only one day. How long does a person have to behave this way before it can be termed madness?	
36.	• Diagnosis is not prescriptive, aetiological or even necessarily procedural • There is silence about other conventional categories of mental illness described in the DSM system (such as depression, etc.)	Interviewee: I understand your question. When a person is cursed, he can be treated. For instance this little boy we have here [points to his son] is on treatment [for a non-mental sickness]; what this little boy takes daily for his treatment, another person might not get to have such medication. For anybody that is practicing witchcraft he/she will sense that there is something wrong when hit with the charm, the individual will then use portions to avert the curse, but if the	

		individual is not a practicing witch he/she will first exhibit some sort of abnormality in behaviour with awareness that there is something wrong but he/she does not what or have what it takes to avert such; the person will just be looking while the charm goes on the body to materialize. By the time the charm is done the individual will not even remember anything; this can go on from a week or a month. Some individuals will take two months before they start misbehaving and that is where the problem will start from because it will bring about an awareness that there is a problem somewhere; if the individual is a practicing witch like we mentioned above the individual will take the matters to the elders, telling them that while she/he was walking or sitting or sleeping, he/she just noticed a strange aura around her body or a sensation inside her body. The elders will now advise the individual on what to use to avert the curse. For instance the person that called earlier on while the interview was going on, that I disclosed to you that he has stroke, he saw himself having stroke in a dream and took the matter to some people but he was not helped in the way he should have been helped. Now the case has gotten worse and the matter has been brought to me and treatment has begun. We looked into the matter and noticed that the family has a hand in his ailment. Cases like these	

		involve death – most especially to the person treating the individual concerned. But my god is bigger than all of them. Thus there is nothing that would happen to an individual that he/she would not be aware of.	
37.		Interviewer: Are there different types of this phenomenon?	
38.	• Typology is qualitative, particularistic, and grounded in reports or observations – not theoretical and reductionistic. There are no rigid classification systems • Types: No responses in conversations in the house; staring blankly into the distance and putting on three clothes at a time; Olororo – one who inflicts harm on others; walking long distances; eating dead animals; eating excreta	Interviewee: Yes, there are different types. There are some cases in which the individual will not necessarily misbehave around the house, but he/she will not respond to conversation. Then there are other types in which when talking to him, he just stares into the distance and he/she will start putting on three clothes at one time; that's when people will know that he/she is running mad. And then there is another type, when he starts, he could begin beating people with anything he sees: a cutlass, a cane, a bottle, an axe, a knife. That type is called 'olororo' (heartless human being). There is also another type: the individual will not talk but he/she can walk from here to as far as Jos. He'll just be walking; he/she will not sleep. There is another type wherein the individual eats dead animals knocked down by cars on the highway. There's another type wherein he/she eats the excreta of chickens, rubs it on his body (his head, hands, legs and face) while talking to himself and wandering on the street – but after wandering around for a while he/she will come home and sleep. That	

		type of person will send everybody that lives with him/she out of the house and only the individual will sleep in the house.	
39.		Interviewer: Are there different causes to the different types of mental ailment or the same causes with different symptoms?	
40.	• Different manifestations	Interviewee: They are all going to behave in a different manner.	
41.		Interviewer: What we mean is this: are there different causes to the different types of behaviour, or are the reactions themselves merely different?	
42.	• Again, non-essentialist framing of the 'matter' • Just as charms are 'different', conditions are too	Interviewee: The thing is that there are different materials and intentions when a charm is done. Are you with me? For instance the make of your cell phone is different from mine; the build is quite different from what I'm using here. This one has no 'memory', yours has 'memory'. You can't write on this one, but one can write on yours. So you know what was used to make yours has more 'quality' than this one. The number of years that your phone will use mine will not be able to use it; that is how it is with the charm.	
43.		Interviewer: Do these conditions have names?	
44.	• Associated conditions with 'wèrè' are 'ìgbonná' and 'inógíje'	Interviewee: Among Yoruba people in Yoruba lands, we have 'ìgbonná', 'wèrè', 'inógíje', but wèrè does not have two names – there is only wèrè.	
45.		Interviewer: Are there other types of mental	

		ailments or this are the main three types of this phenomenon?	
46.	• Closely related conditions are 'wèrè', ìgbonná (caused by òtútù) and inógíje • It takes experience to distinguish these forms of mental disturbance	Interviewee: These three types I called for you are different from each other. With ìgbonná, this is caused by òtútù [cold], but if quick care is not taken to use some medication so that he can be well, the individual will be behaving like a mad person and if left alone to rush outside, the person will be mistakenly identified as wèrè, whereas he/she is suffering from ìgbonná that later became wèrè. So you understand that they are different. With inógíje: this is when someone just suddenly places a curse on another being and that individual starts behaving in an abnormal way. This is different from wèrè, but the symptoms are similar.	
47.		Interviewer: How can you tell the difference between them?	
48.	• Ailments are distinguished by reactions to interventions like whipping and incantations • Identifies '*wárápá'*	Interviewee: When these cases are presented before us, the first thing we do is to observe closely…the one who is wèrè…if you whip him with the cane or speak to him with words of incantation, if he is wèrè, he will calm down – though he will still behave in the wild ways that he wants to. But if it is inógíje, when words of incantation are spoken on the individual to put calm him down, he absolutely calms down and slumps; he won't cause any issue, he will just stare into nothing in particular; that's when you will know that	

		this one is not in the category of people that are wèrè. The medication you use here would be much different than the one you'd use for wèrè. By the time we apply the medication – which is the eatable one – the individual's curse will come off his body. There's another type which is called wárápá –anyone who suffers from wárápá the individual will walk aimlessly and also fall down intermittently with foam coming out of his mouth. Most of the time, when people see this, they mistake him for wèrè: people see him and say he is mad whereas he is not mad. If they use medication, the individual will vomit the 'venom' inside him, and will be given treatment to calm him down.	
49.		Interviewer: What causes wárápá (epileptic condition with foaming)?	
50.	• Identifies onset of wárápá	Interviewee: They cause it to happen to other people.	
51.		Interviewer: How do you cure an individual that has cold and suddenly leaves the house?	
52.	• Treatment of *ìgbonná* case does not involve beating, but a herbal administration which expectedly sends the client off to sleep	Interviewee: That one is simple; we will make herbal solution for the person. I just made one for an individual now which I just gave to him. For us to detect that it is ìgbonná the individual must have been running round the house aimlessly before appearing here, then only are we going to give him herbal solution. He doesn't need to be beaten at all. The individual will sweat it off and go to sleep; when he/she wakes up we will now	

		give him a proper medication.	
53.		Interviewer: Can you give us a detailed account of how you identify an ailment, and how you treat them from when they are brought here till when they become hale and hearty?	
54.	• Diagnosis of *wèrè* often begins with observation, the use of enforcements to contain the client, incantations and direct confrontation, consultation with family or community, use of *ìpábò* or *ètùtù* to restore balance with spiritual worlds, and ascertaining treatment by immersing client in normal relational contexts – "give him a hoe"	Interviewee: If it is in the case of wèrè, he won't be able to sit the way we are all seated; besides his hands and legs would be tied when he is brought here, but even with that the individual would be struggling to cut loose. On seeing such, before I ask any question, I would enter into my room or closet as the case may be, and bring out my charm and speak words of incantation on him and ask him to calm down; only then can we now inquire from those who brought him/her. It is those who brought him/her that will now say how he has been behaving at home, at the work place, when it happened, where they have taken him to, and what was used before. They may report to us that they took him somewhere else, but did not pay close attention to what was used, and because there was no improvement, they have brought him to me. So on getting to my place we will then ask about the person's name, after which we will then know if we are to do ìpábò or ètùtù (sacrificial ritual to appeal to spirits/gods for help). If it is required we will do it. After doing this, we will then commence the treatment. After the treatment has been done	

		and we want to ascertain that treatment is at work we will take the person to a farm land where crops like corn, sugarcane, yam, cocoa yam are growing on it, we will then give the individual a hoe for him to till the land with it, if it were to be a normal being the individual will separate each crops from each other before tilling the land, if the individual does this, then we know for sure that the person's 'brain' has 'awoken'. Only then can we start sending him on errand jobs. I hope you understand my explanation.	
55.		Interviewer: Yes, thank you. We've learned that other Yoruba traditional healers use some form of divination to consult Ifá to intervene in cases like the ones you've been describing. Do you also engage in such or are your applications limited to agbó?	
56.	• [observation] Displays object – small, wrapped…alludes to the non-ordinariness of the world	Interviewee: You see this thing that is right here? It is called érindélógún.	
57.		Interviewer: Do you consult this thing right here or what?	
58.	• Consults *érindélógún*, 'who' determines if intervention is to be made or not…if yes, an *ètùtù* is made	Interviewee: As soon as they bring in the individual we will ask for his name and ask érindélógún about the individual; if it is something we can do here, which we can handle, and which would not bring problems on our own children, we would see it here (érindélógún) and continue. Once we see it we will continue, but if érindélógún tells us not to do it, we will declare to them that we	

		cannot proceed, and that they should take him somewhere else. If, however, we can do it, we would let them know and also let them know about the ètùtù (sacrificial exercise) which would be required of them. As for me I don't collect ram or goat as sacrificial lamb because it is against our custom here. If the ètùtù requires us to kill a ram or goat, we would direct them to another place to go and kill the ram or goat; by the time they are done with the killing of the goat or ram they would now come back.	
59.		Interviewer: Why don't you kill rams or goats in your place here?	
60.	• Emphasizes retributive justice and reasons for requirement of materials for *ètùtù*	Interviewee: Thank you. The reason why we don't collect ram is because by the time we grow old…because of our children…every animal that a spiritual herbalist collects from his clients has its costs on the healer. By the time the herbalist grows old and falls ill, the child would want to take care of him and treat him. When he goes to other healers for their aid, as his father had always requested an animal, they will also request that animals be killed before his father can be well again. If he goes to 20 places, he will have to kill 20 animals for the sacrifice. But if I don't collect animal for sacrifice, they [other healers] won't request [when I need them]. All they would do is to give me medicine. When my father was ill I never took him out for any spiritual intervention; I never collected	

		animals from anybody. Instead I hired doctors that would come to the house to treat him, and each time I go out and people ask about my father I tell them he's not feeling too well. Some would come and check him out and just conclude that he has come of age. That's why we don't collect animals for sacrificial exercise.	
61.		Interviewer: How do you receive messages from érindélógún? Do you hear something speak, or how exactly do you communicate with it?	
62.	• Receives messages in form of signals / configurations from thrown cowries • Feigns ignorance when cowries reveal malicious intentionality of potential client	Interviewee: You see these cowries here that I am showing you [throws cowries on a small table]? If I inquire about your visit - whether it is for good or for ill – once I ask and throw it on the ground…can you see the configuration, the way their faces look up? There's a message it's passing across, words spoken. If it is for us to grant you an audience, it would tell us, but if it tells us that the visiting would not yield anything then we would not want to grant the audience – or rather we'll pretend and tell you that we have no idea what you are asking. You would be left wondering if there was something that hindered us from talking. Several people have been here to interview us, but for some reasons or the other we have not granted them audience because most of them are not genuine with the interview. But on the other hand my work is clean. If the police should	

		come today I will grant them an audience; if they search my house for evidence they won't see any bad thing. That's why I granted you the audience because there's nothing to hide. Moreover I am also popularly known as a clean fellow by my neighbours.	
63.		Interviewer: Is it your father that taught you everything you know?	
64.	• Learned from father	Interviewee: Yes, it was my father.	
65.		Interviewer: Do you always succeed in treating your clients? I mean, do they get 'well' after they are brought here?	
66.	• Recalls successful treatments	Interviewee: By the grace of god, everyone brought here has regained consciousness, and they have also gone returned to their normal daily activities and businesses.	
67.		Interviewer: How long did it take you to treat this people?	
68.	• Longest duration of treatment is 3 months	Interviewee: Every one of them did not take more than 3 months.	
69.		Interviewer: Can you talk to us about one of the patients you treated and how you went about it? Some kind of memorable event in your career as a healer?	
70.	• Recounts experience of healing a client successfully	Interviewee: Well, if I understand your question very well, there was none that gave trouble during treatment – because once they are brought we inquire about what is wrong with them and give them the medicine to cure them. The most difficult ones were always brought for my father. There was one that	

		was from U.S.A. (United States of America), who was first taken down to Akure [Ondo State, South West, Nigeria] before somebody from there finally brought the man to my father. The man is a lawyer. My father followed him back to where he came from. On getting there my father requested he should be bathed right there in the room. My father then requested for soap to bath him with. After this, he (my father) realized that the individual could not be cared for in the room because the person who caused his condition was living with the person. So my father told them to arrange for a car for him to be transported from Akure to this place here. It was a critical case for the individual: his limbs were paralyzed; his arms, his whole body was numb. As soon as he was brought here, every necessary preparation that was needed began with the exception of asking for goats and such things. I witnessed all the preparations my father made for the case. After that my father started administering drugs for him (not pills, but herbal concoctions) to get well. In no time the individual started talking: he stood up from the bed which he was stretched out upon, and he requested for some reading materials, and began reading while lying down. Then we started using another type of medication to enhance his healing. We would wash and bathe him regularly. After a while he started	

		lifting up his arm, his legs and every other part of his body. Having full control of his body, he stood up on his two legs. However we noticed that his legs were swollen up, but there was nothing to worry about because we have a soap which we use in washing such type of ailment off an individual. So in no time we started washing him with the soap and we were also administering drugs to him. Soon he started walking, and then slowly but surely, with the help of the little ones around him, he gained strength. He was an elderly man, but he learned to walk with the help of the little ones. Before he left he was playing football outside in the field over there to enhance his healing. When we fully realized that he was well, he had to leave, but before he left he told my father that when he gets back to the United States, he would send something to him – and though we confirmed that he did send something to us, we did not receive anything. This is what happens when you hear people saying that we herbalists are wicked, because this individual we treated will think that the gifts were delivered to my father – not knowing that it was secretly received by another person. Our job is to do the work well and heal him – even if we receive nothing in return.	
71.	•	Interviewer: Is there some advantage to be gained in experiencing this phenomenon?	
72.	• Denies advantages to ‘mental	Interviewee: There is nothing good about it;	

	illness' based on social repercussions	it's a public disgrace. God will not allow one to be wèrè. For instance, if I run mad, and I am healed and helped to a state of wellbeing, and my child offends me so that I beat him severely. When the child comes out of the house, people will inquire what he did to deserve such a beating from the father. The child says he did nothing. Then, people will begin to think that I am experiencing some sort of relapse; they'll say "Ah! That thing is walking over his body again!" Whereas it is the sin the child committed that provoked such anger from the father which resulted in a beating. But because I have had that experience, people will think this way. That's how embarrassing the case can affect an individual.	
73.		Interviewer: If you have someone that walks up to you telling you that he/she is hearing voices, whereas no one is talking to the individual even though what is been said is 'good' to the person, what will you do?	
74.	• 'Hearing voices' is normal and often very advantageous to the recipient	Interviewee: Such cases abound. Take an example…there are some people who ought to be in church working with others, but are not to be found there. I am sitting here answering your questions. If this is not where I ought to be, I will definitely leave because if I continue for long I will start hearing voices that the job I am doing currently is not what I should be doing - that where I should be is the church or mosque delivering a	

		sermon and that if I don't leave here I would answer for it. It is very normal for us to experience such situations. This is quite different from someone that is mad.	
75.		Interviewer: In the west, clinical psychologists would consider this a form of madness.	
76.	• The 'West' does not subscribe to invisible forces. It is their culture; they try to reduce everything to coincidence or accidents • Asserts authenticity by juxtaposing himself with scam artists posing as healers	Interviewee: This is not madness. The thing is that they don't practice such thing in their environment because they have churches in within their vicinity but they don't tell people that "before this time tomorrow something will happen to you". You won't hear the white man saying "your family is about to harm you". They don't do that because they don't believe in that. A white person believes that whatever he is experiencing is supposed to happen to him; they don't believe that they are being haunted by individuals with magical powers. They don't believe that. That's just their culture. But here in Yoruba culture when something happens which is not supposed to happen, they would tell the concerned person to go and seek help from native doctors or an herbalist. Unfortunately, sometimes, for the individual he or she might seek help from someone who is hungry, who hasn't seen a customer in a while; such a person will just mislead the seeking individual because of the money he wants to collect from him. But a sacred healer will tell the truth to the individual – telling him that	

		"this is mere sickness; go and treat yourself!" If it is severe then herbal administration would be done for it not to reoccur. That is coming from somebody who knows his job. If you look closely at the village you will notice that there are some other little herbalist around who are '419' [scam artists] who would claim that they serve Ògun, Ègun, Èsù [Yoruba deities], knowing fully well that there is only one Ògun. We have Ògun in my backyard; we have Ògun in our hometown in Adó-Èkìtì. If it does not appear to the person we will not tell the individual to come and pay respect to the god; if we see that an accident will occur then we tell the individual to pay respects. And if the individual is not capable, we tell him to bring materials he can afford – a dog or hen, oil, bitter kola. If the individual has money we would request him or her to buy a male dog for the use of averting the accident. That's what we do.	
77.		Interviewer: What do you think conventional psychologists – trained in Western-oriented paradigms – are missing? What is that we are do that we ought not to do and what are not doing that we ought to do? What do you know that we don't?	
78.	• Understands modern mental healthcare as "tablets" – which cuts a contrast between their work and the work of the modern clinician	Interviewee: You see, in the land of white people, the treatment they use for their people is tablets; they have the idea that it is 'brain problem' that affects those who have turned mad. There is one boy that was brought from	

	• Emphasizes critical inadequacy of mental illness paradigm with account of non-recovering boy • "One need not spend so much on tablets"	my brother's house. As soon as he was brought, they ordered those that brought him to take him to where he would be taken cared for, but his parents did not believe that he would be well in the hands of an herbalist. Instead they insisted on taking him to Árò Neuropsychiatric Hospital in Abeokuta, where proper treatment would be administered to him. However, after going to Árò for treatment he still did not get well. Today, they spend a lot of money just to make sure that he gets well; they spend close to fifteen thousand Naira every 8th day. They go there for treatment. As we speak right now, for over 4 or 5 years, that boy is yet to be well. He is in his village – still struggling with the sickness. As at the last two years when I saw him, his case had gotten worse; I saw him in a mad condition (I saw him putting on 6 clothes at the same time). Now he has been left alone without any care. If they had used the money they were spending in Árò every 8th day to treat him here, they would have had different results, because others were treating the brain, while the sickness is in the body. Abroad, when an individual is sick, they treat the brain instead the body. For example, when I complain of stomach ache, and you go ahead into my father's house and prescribe malaria drugs for me…if I use it, will it solve the problem?	
79.		Interviewer: Are you saying that they don't	

		know but they think they know.	
80.	• "Whites' have reductionistic knowledge…they build things, but they are oblivious to invisible forces"	Interviewee: What the white people have knowledge about is how to build things – like this handset – they couple things together. If someone needs 'blood' in an engine they use there, they'll give the 'blood'; if it's the blood of a human, they'll give; if it's the blood of a goat, they'll give. When they are done combining, they'll add mercury and when finished, they'll put on their engine. How they treat their patients is very different from how we treat ours. They don't pour palm oil on yam to appeal to the gods – we do. They are oblivious to all these things. We aren't.	

APPENDIX D: TRANSCRIPT FOR INTERVIEW [P4] WITH INITIAL CODING AND SUBORDINATE THEMES

R	Researcher's Analysis of Transcripts	Transcription of Interviewer's Questions and Interviewee's Responses	Subordinate Themes
1.		Interviewer: We will start with questions of minor import and then proceed to deeper questions. What is your name?	**Describing mental illness (explanation as narrative contextualization)** [R16a, R28a, R28b] **Difficulty with managing clients** [R10] **How mental illness emerges** [R16b, R20b] **Inherited healing practice** [R6] **Awareness of heritage, competence and self-identity as healer** [R8, R12, R18, R22a, R30a, R30b] **Healing as justice** [R22b] ***Ayé* and the Non-ordinariness of objects and everyday life** [R38a, R38b, R40a, R40b, R40c, R40d, R44a, R44b, R44c, R44d] **Esoteric procedures and materials employed in treatment** [R26a, R26b] **The inadequacy of Euro-American mental illness paradigms** [R36a]
2.		Interviewee: [Names given]	
3.		Interviewer: How old are you?	
4.		Interviewee: 1972. That's how many years? 41 years	
5.		Interviewer: Did you learn this practice on your own or did you learn it from your father?	
6.	• Inherited healing practice from father	Interviewee: My father taught me and then I went out to learn more in addition.	
7.		Interviewer: What year did you start precisely?	
8.	• A sense of engagement and history	Interviewee: Hmm… I have been at this for long. I believe from 1993.	
9.		Interviewer: In a month, how many mentally challenged persons have you attended to and possibly treated successfully?	
10.	• Expresses reluctance (and difficulty) with managing 'mentally ill' clients	Interviewee: You see I have treated about… they bring them to me, but I very often turn them away. The treatment of these persons has repercussions that I don't like because sometimes when one ties them down and the herbalist goes out, the wèrè might loosen himself and go out and hurt passers-by, children or neighbours. I don't like it! However, I have treated about 3 or 4 cases.	

11.		Interviewer: And those you have treated got well?	**Diagnosis and intervention procedures** [R20a, R24] **Transferability of skill and knowledge** [R34, R36b] **Maintaining Wellness** [R42a, R42b]
12.	• A history of successful intervention	Interviewee: Very well.	
13.		Interviewer: Is this where you were born?	
14.	•	Interviewee: Yes. This is Adó-Odò, Òtà.	
15.		Interviewer: In your opinion, what does it mean to say someone is mentally challenged or 'mad'?	
16.	• 'Mental illness' as loss of control, access to spirits, loss of proper relations • Phenomenon arises because 'a man smokes'…inherited from 'blood' (family), curses (which leads to obliviousness to condition)	Interviewee: You know that a person who has turned into wèrè cannot be such as we are right now. He will be seeing many spirits; he has no more control over himself anymore. A person is said to be mentally challenged if he no longer thinks like a normal person. In some cases, it comes because of what a man smokes. That's number 1. Number 2… there are some cases in which the problem is inherited from family circles. There are some families in which when children are born, it is in their blood that one of them loses his mind. Number 3, when someone is cursed…they'll say he should misbehave – whatever he does he should not have any recollection of it.	
17.		Interviewer: Which one has to do with spirits [ayé]?	
18.	• 'Ayé' involves curses and problems emanating from sour family relations	Interviewee: That's what I'm saying – the one which involves family problems and the one in which one is cursed. People do it when they are often angry with each other.	
19.		Interviewer: Since you don't really accommodate clients, how do you treat and	

		address those that are brought to you? Can you walk us through the processes through which you determine what is assumedly wrong with a person or his context?	
20.	• In approaching healing, healer makes skilled observations, asks relevant questions, and confirms reasons for phenomenon • Emphasizes that apparently harmless, ordinary 'objects' (like a misplaced strand of hair) can cause mental illness	Interviewee: When a person is brought, there are questions I ask which are part of what I was taught. You won't know what transpires, but within my spirit I know what to do – because that's my training. If it's a malicious spirit-force involved, I will know. Take for instance, the last patient I treated happened to be drug addict; he was coming from a saloon where he went to get his hair cut. On his way back he saw his friends taking igbó [psychoactive drugs ingested by smoking], so he joined. Suddenly a tiny piece of his hair dropped inside the mixture and he ingested it. And you know once such is ingested the person will turn mad.	
21.		Interviewer: So what did you do when the boy was brought?	
22.	• Affirms proficiency in detecting roots of phenomenon • Acts as 'judge' to carry out retributive acts on perpetrators	Interviewee: That one wasn't difficult. As soon as he was brought I already knew what to use to treat him. There are some performances we do to treat people – we may not have the materials on ground, but we will find out. But if we find that there are other influences involved, perhaps in his family house or a woman somewhere he wronged and we ask him to seek forgiveness, and he is not forgiven we know what to do so the curse returns to the sender.	

23.		Interviewer: So there's something you do that made the person get better?	
24.	• Uses rituals called 'òképè' to remove curses – this involves washing the head with specific soaps…this removes 'òtútù itá'	Interviewee: Yes, we know what to do. When, in this case, we have begged the people offended, and they have accepted… "ok, we're ready to remove the curse!" If they refuse to confess their doing, the curse will return to them and hang on their heads. Do we understand now? The person who has been cursed, once we know one has been cursed, there is something we do for people that are cursed that is called òképè…once someone is cursed and we do this thing, the curse will move away from his head – that is if we know such a person has been cursed…we would use it to wash the head. Is it not god they called when they made the curse? When we do this, the thing will take command – the 'spirit' will move away from his body. It's like…spirit, it is òtútù itá they call it.	
25.		Interviewer: Does madness vary? Are there notable types and categories of these conditions – and there documented ways and advanced methods for healing? Are they teachable?	
26.	• Refuses to share knowledge of types of mental illness • Affirms different curative measures	Interviewee: Yes, there are – and we can teach them, but you know we cannot share them with you; we can't just toss it on the ground. We have it. If I say, "take from this tree, this plant, get this oil"…if you see someone who is severely challenged, and he	

		is bound and tied and held down, and he refuses to take his concoction, there are things we do. Once we give his something, a different preparation, and he swallows and ingests it, in 15 minutes the herbs will weaken him. The cure for madness gotten through intake of drugs is different from madness gotten through family curse.	
27.		Interviewer: Can you talk about the different categories of conditions presented to you so far?	
28.	• Non-reductionistic, experience-based, allegorical understanding of 'mental illness' • Identifies mental illness as loss of control	Interviewee: One who has gone mad behaves in certain ways. Some will take cutlasses into their hands, others will start laughing hysterically, another will take off all his clothes and start going. You know he doesn't know what ails him. A spirit has come in and has taken command. If it says, "cut people with the machete", he will do it. That's why we often tie them to the ground. They are like people who are sick – when they go to the doctor, they look into his blood and see 'typhoid', 'fever' – so also we know what we see when they are brought here.	
29.		Interviewer: You said your father taught you. Can you tell us about the history of this art?	
30.	• Distinguishes between colonial traditions and indigenous traditions and history • Legitimizes practice as historical and embedded in family and group consciousness	Interviewee: All of us have known that black people have been here for long; you know 'Christians' and 'Muslims' came from somewhere else – and we took them in, and they came to tell us that "this is how you must do this – this is how you must do that";	

		but we all had our own indigenous arts and beliefs and community practices. Do you understand? Everyone had their arts. This one has been long in my family – handed down to me from my father. I am the only child of my father practicing now.	
31.		Interviewer: Are you right now training your own children in these ways?	
32.		Interviewee: Yes, but before a child knows this, the child will have to go to school first.	
33.		Interviewer: Do you somehow intuit who amongst your children will make a good healer?	
34.	• Wishes to perpetuate traditions and art with children	Interviewee: Yes, I already know who is going to do my work – though I teach all of them the wisdom, so that whatever they become – doctors, engineers – they know what to do when they meet certain challenges; they know which leaf to pluck. However, one of them is being prepared to do the job I leave behind. They will first go to school.	
35.		Interviewer: I don't understand why you'd want to send your child to school. At school and formalized psychotherapeutic practice, there is little tolerance and little room for these practices. We are taught that the 'real' thing is what we are doing. Are you not concerned that these indigenous practices are dying – and that schooling may actually work against preserving these arts?	
36.	• Reveals information on covert	Interviewee: Eh…no. What happens is that	

	dependence of psychiatry on shamanic practice • Believes even an 'educated' child can carry on with his practice	the child who knows this art…who is close to…you see, even those that are educated, who are not trained in our practice visit and consult us in ways that will not let others know. But the child that has heard and understands, that has been taught these things of our land, cannot do away with them forever….Anyone that has experienced the efficacy of our art will believe in what we do. The white people don't recognize our work.	
37.		Interviewer: What is so important, so crucial about what you do that is missing in the understanding and appreciation of the 'white man'?	
38.	• Alludes to a plurality of 'spirit' or trans-local energies • Recounts remarkable local accounts of spiritual intervention	Interviewee: What happens is that each context has its own power; each has its own spirit. For example, there was a man – that man… he died. He was buried outside here. He was a medical doctor. Don't you know his hospital around here?! He died and was buried. A doctor. He came to Owode here, became a doctor and built a big hospital here. There was no…I mean, if you were about to die, or even in death, he could command your spirit back. If a woman couldn't give birth, he could change that. That's his power. One day, some visitors came from his town, we didn't know them – they just showed up in our land. Something happened and they went to that same hospital. They saw the doctor and exclaimed – "is it not this man who died and we buried?"; as soon as the doctor saw them,	

		he vanished. We haven't seen him till today. Do you understand? He not only built a hospital, he got married here and had children!	
39.		Interviewer: Our current paradigm does not accommodate such stories about 'spiritual intervention' as a cause for mental illness.	
40.	• Affirms Ayé or the role of hidden forces in giving rise to mental illness • The incommensurability and plurality of approaches to wellbeing • The non-ordinariness of the world • 'illness' and 'wellbeing' are local constructs	Interviewee: The 'white man' cannot believe it – because over there they do not see that there are hidden forces (ayé) that people exploit to disturb others. But now things are changing – people are getting it. You know that now – through popular television programs like 'Nkan be' people are realizing that things happen. Now things are changing. This story of the doctor I told you…if I ran into someone and told them the tale they'd find it hard to believe. But now, on television, these mysteries are becoming very popular. The 'white man' will not see the way we see, because they do not believe people do things to other people. But here, we know that these forces are here – because we have terrible things in our hands. There are some things, for instance, that should not touch you. If I were to put this thing here on your body, you won't even give it any thought. You'd say: "Is this not alligator pepper?" Whereas here, this has powers and we have seen it. That's why we believe in the ways we do.	
41.		Interviewer: What then does it take to live a	

		mentally healthy life? Is there a way to live so that 'wèrè' will not come?	
42.	• 'Staying in one's place' as wellbeing • Some aspects of mental illness are self-inflicted…due to carelessness	Interviewee: What I will say is that we are often the architects of our own problems. When someone has money now, he'll let others know he has money – and that often annoys people. If we go gentle, there'll be no problem. Don't go beyond your boundaries; stay in your place. Don't go about drinking too much. One should watch oneself.	
43.		Interviewer: What do Yoruba people say about spirits and how people interact with them? Are they only accessible to some people? How does the 'spiritual world' interact with the 'physical world'?	
44.	• We are 'ayé' – fluid and non-ordinary ourselves • We abide in an 'ecosystem' of invisible and visible forces • The interactional dynamics often create disturbances • Recovery and healing is a negotiation of powers	Interviewee: [Laughs] May Olórun have mercy on us! As we are here, we are forces (ayé) ourselves – and to the passers-by outside who don't understand what we are doing in here, we are ayé. Perhaps we are having a sinister meeting, they do not know. That's what we call ayé. And there are higher powers. You know that? Right now, we believe that Olórun created us – and it is not only us that were created. Olorun created other beings different from us – you know? There are others who walk in the forest, there are spirits…You see, these spirits hide in the woods, but as we build more and more houses and expand, we encroach on their spaces so that they do not have any place to live. We can't blame them. So they	

		sometimes possess a child, and disturb us. That is life. But powers are bigger than other powers.	
45.		Interviewer: Thank you very much sir!	
46.		Interviewee: It is Olórun that should be appreciated.	

APPENDIX E: TRANSCRIPT FOR INTERVIEW [P5] WITH INITIAL CODING AND SUBORDINATE THEMES

R	Researcher's Analysis of Transcripts	Transcription of Interviewer's Questions and Interviewee's Responses	Subordinate Themes
1.		Interviewer: We'll begin with meeting you. We want to ask you few questions, but I'd like to know your name, sir.	**Describing mental illness (explanation as narrative contextualization)** [R24b] **Diagnosis as non-divination** [R52] **Non-formal relationships with clients** [R44a] **Types of mental illness based are particularistic, descriptive and allegorical** [R26] **Lack of standardized healer-client relationships** [R18] **Inherited healing practice** [R6, R8] **Awareness of heritage, competence and self-identity as healer** [R12, R24a, R30a, R46, R50] **Narrative, non-reductionistic differentiation of manifestations of mental illnesses** [R20, R22] ***Ayé* and the Non-ordinariness of objects**
2.		Interviewee: My name is Doctor [Names given].	
3.		Interviewer: Thank you, sir. How old are you, sir?	
4.		Interviewee: I'm…46 years.	
5.		Interviewer: Was it here in this land that you were born?	
6.	• A sense of belonging and history	Interviewee: It was here indeed. Ìgodonu.	
7.		Interviewer: How did you begin this healing practice? Did you learn it from your father or elsewhere?	
8.	• Practice inherited…trained by father	Interviewee: My father taught me and handed it over to me, and I also practiced elsewhere.	
9.		Interviewer: So when you learned enough, what year did you start precisely?	
10.		Interviewee: 1986.	
11.		Interviewer: So since then you've been taking care of people?	
12.	• Alludes to competence as healer	Interviewee: Right till this very moment.	
13.		Interviewer: Let's take a month…how many such persons do you attend to within a month?	
14.		Interviewee: Concerning what? Is it "mental disease" or…	
15.		Interviewer: Yes, sir.	

16.		Interviewee: About 10. They could be more or less in a month.	**and everyday life** [R34d, R40, R42] **Mental illness as access to other worlds** [R32] **Esoteric procedures and materials employed in treatment** [R48] **The inadequacy of Euro-American mental illness paradigms** [R34a, R34b, R34c] **Diagnosis and intervention procedures** [R28, R30a, R30b, R36] **Ascertaining success of treatment and recovery** [R44b, R44c]
17.		Interviewer: So you take them into your home?	
18.	• Accommodates clients	Interviewee: Yes I do.	
19.		Interviewer: So, what do you understand as the meaning of 'mental illness' [wèrè]? What is meant when we say that someone has 'gone mad'?	
20.	• Uses metaphors of heat and inflammation to explain cause of mental illness	Interviewee: Well, it would like someone's brain [opolo] has become 'hot'. The brain must not become 'hot'. That's the cause. Then it becomes "mental disease". But if 'it' comes through the feet, then it becomes 'stroke'. Does what I say make it clear for you?	
21.		Interviewer: Yes, sir.	
22.	• Identifying manifestations of mental illness	Interviewee: There are others that speak with themselves and they just stare at you. Did you see the others behind [referring to his clients in the house]? Their hair must not grow…or else you'll just see that they start to say things they should not be saying. There are some that are very strong. One broke three of these chains of this size! You know this is 'anger'?	
23.		Interviewer: So are there different types of 'madness'?	
24.	• Assertive about experience and knowledge base • Uses allegorical accounts to articulate typology – fluid/organic	Interviewee: Ah yes! There are. There are some – when I simply say: "Remove your clothes, walk out and continue walking into the forest!" It may be that the person did	

	categories	something offensive to another. That is what will happen – he will spend the rest of his days wandering about.	
25.		Interviewer: Alright, so there's 'anger' and then this. Are there others?	
26.	• Identifying sources / types of mental illness	Interviewee: Yes. Plenty. There are some who ingest drugs like cocaine. Others have curses placed on them.	
27.		Interviewer: How do you know which is which?	
28.	• Some cases require the use of force to manage clients	Interviewee: There are some that come…that are so strong that we have to hold them down and bind them. Then we force down into their mouths an herbal concoction to get them to sleep.	
29.		Interviewer: How do you know what to give them when they come? Or is it the same concoction you give in all cases?	
30.	• Asserting expertise • Clients are observed and learned from • There are various degrees of herbal administrations – depending on observations and case	Interviewee: Ah! Is it not my work? When we observe them and watch them, we know what to give – based on their behaviours and our questions to those that brought them. There are categories of administrations, methods depending on the situation. But in all cases, initially, we give a herbal mix to calm them down.	
31.		Interviewer: Yoruba people have a firm belief in the influence of 'spirits' on behaviour. In the West, there is a strong idea that anomalies have a biological basis…	
32.	• Mental illness as access to invisible realms	Interviewee: As we sit here, if one has that 'disease', he could begin to see otherworldly	

		beings, dead people…we will not see, but that person will see, and he will be saying: "There they are! There they are! They've filled up the whole compound!"	
33.		Interviewer: Yes, we understand. But what we are saying is that the 'white people' do not believe in spirits…	
34.	• The inadequacy of modern psychiatric care • Understands conventional mental healthcare as drug dispensing • Narrates account illustrating covert dependence of conventional clinicians on indigenous conceptions of wellbeing • 'Ayé' as a principal factor in mental illness	Interviewee: It is drugs they know about! Okay, there are two psychiatric centers that I know about, one in Árò and one at Yaba – in Ogun and Lagos states. I have never been to those places before. But when they came here – the West African College of Herbal Science, they took me there. We paid for courses. I went to do a certificate course, a diploma. We go to 3 hour classes once a week. We worked with auxiliary nurses. During my time there, one of our lecturers, a doctor, said he wanted to see me in Abeokuta. When I got to Árò, he showed me 4 people and asked me to figure out what was wrong with them and how to heal them. I said 'drugs'. He laughed at me and said they had already been given 'drugs' and they weren't helping – their problems were still there when they woke from their sleep. He said, "these ones are not drug problems; these are issues with ayé!" He then solicited for my help and asked me if I could take them for treatment. I said I would talk with my people.	
35.		Interviewer: How do you know if it is ayé or drugs that is the problem in a case?	

36.	• Highlights proficiency and supporting ritual/consultative exercises as crucial to successful intervention	Interviewee: We will know. We perform the various rituals (ètùtù) to find out, and various concoctions to purge the many substances taken.	
37.		Interviewer: In your opinion, why is there a high prevalence of substance-intake	
38.		Interviewee: I don't know! I don't know that at all!	
39.		Interviewer: What does 'ayé' mean?	
40.	• 'Ayé' implies largely unknown, malicious (sometimes benign) intentionality that provokes and influences events and behaviours, and alludes to the non-ordinariness of living	Interviewee: If I go out to my shop and come back in, and one of my items went missing, I can swear on such a person and say: "Whoever did this, it will be so and so for the person!" And it so happens that some would have accidents, some would die on the road, others would turn 'mad'.	
41.		Interviewer: Is there a way to go through life without encountering these problems?	
42.	• Ayé is all-encompassing; wellbeing is a continuous negotiation with sacred order	Interviewee: Nobody can!	
43.		Interviewer: How will you describe your relationship with your clients? Is it cordial, elderly, professional? How do you relate with them?	
44.	• Affirms cordiality and organic relationship with clients • Recovery and healing is ascertained by the assumption of proper roles and relations (sending errands, commensurate responses to queries…)	Interviewee: There's no problem there. When one is friendly with the people who bring the client, and talk over the issue with them, all is well. They'd often ask: when will he be fine? And I may tell them: "I didn't put him in this condition!" When things go well, we eventually test them [the clients]. We often	

	• Being cautionary with clients who constitute a danger to the healer or his family	send them on errands to see how they respond. When he answers like he ought to, we know he is alright. There are some that do not respond as they should. There are some who come with clients that have taken lots of marijuana – you can see it on their bodies. They look shrunken. We have what to use that 'wakes' their brains up again. And then we speak to their families to bring this and bring that. I put my clients in a separate room however; I take responsibility for them but keep them away from others, because they are often wild and can harm others.	
45.		Interviewer: So, let us clarify something important. You have different approaches for ritual cleansing and herbal administrations according to the different cases, and these are based on your observations of the clients?	
46.	• Confirms multiplicity of approaches and skill-sets	Interviewee: Yes.	
47.		Interviewer: Can you tell us what you give them, or show us what you offer them?	
48.	• Retains secrecy of plant/herbal remedies and shamanic procedures for healing	Interviewee: No, I cannot.	
49.		Interviewer: How do you know what is happening with your clients?	
50.	• Emphasizes aptitude based on experience	Interviewee: But I have said it before – I ask them questions. Based on their answers I know what to do.	
51.		Interviewer: Is your knowledge based on access to the 'spirit world'?	

52.	• Non-consultation of deified beings; employs herbal remedies and experience as practice	Interviewee: No. I don't consult the gods or spirits. I work with clients based on my training and my experience.	

APPENDIX F: TRANSCRIPT FOR INTERVIEW [P6] WITH INITIAL CODING AND SUBORDINATE THEMES

R	Researcher's Analysis of Transcripts	Transcription of Interviewer's Questions and Interviewee's Responses	Subordinate Themes
1.		Interviewer: Just like we said the first time we paid you a visit, we'll be asking questions regarding your understandings of mental illness, your practice, how you interpret these behaviours, and how you approach healing. First can we get to know your name for the recording?	**Inherited healing practice** [R6, R10] **Awareness of heritage, competence and self-identity as healer** [R14, R32, R42a, R42b] **Sources of mental illness** [R16, R20a, R20b, R20c] **Efficacy of intervention** [R28, R32] **Partnership with the paranormal in detecting and evoking healing** [R18b, R38a, R38b, R44, R40] **Manifestations/symptoms of mental illness** [R18a] **Client belief and trust in healer** [R46] **Non-formal expertise** [R26]
2.		Interviewee: [Names given]	
3.		Interviewer: And how old are you sir?	
4.		Interviewee: Me? 35.	
5.		Interviewer: Did you learn this practice on your own or did you learn it from your father?	
6.	• Affirms reception of non-formalized training from father	Interviewee: My father taught me and then I went out to learn more in addition.	
7.		Interviewer: Thank you sir, is this where you were born?	
8.		Interviewee: Yes.	
9.		Interviewer: When did you start this job? Did you start on your own or did your father teach you?	
10.	• Establishes continuity in practice	Interviewee: I practiced with my father before he died. When he died, I took over his practice.	
11.		Interviewer: You practiced with your dad before he died. So you took over after he died?	

12.		Interviewee: Yes.
13.		Interviewer: Okay, sir…on the average, how many clients do you deal with? Is it only those with 'mental problems' that are brought to you or other people as well?
14.	• Confidence in therapeutic prowess and awareness of limitations and constraints	Interviewee: Anything I'm asked to cure, I'll cure it. Some cases, if I'm asked to [intervene], I won't.
15.		Interviewer: Okay, so if someone is brought to you now and you decide the person is mad, what does that mean to you?
16.	• Identifies sources of mental illness (substance abuse, carelessness, malicious intentions, curses)	Interviewee: If someone is brought to me for healing, there are some…it is smoking marijuana has troubled them…marijuana. Some other people, it is smoking marijuana that has troubled them; for others, it's cocaine. Some people are over-pampered or play too recklessly. Some other people are being 'done' to. Some other people are cursed.
17.		Interviewer: So, if someone is brought to you now, and the persons who brought him state their observations about the person's behaviour, what do you use to determine whether or not the person is 'mad'?
18.	• Identifies the onset of problematic behaviour with incoherence in mannerism and speech • "Olórun grants us success" – partnership with the preternatural	Interviewee: When we look, some people behave erratically…the words won't be coherent anymore. Some won't sleep. Some people run temperatures – temperatures that can lead to madness…if not treated quickly, will surely result in madness. We do that too. There are some that have been cursed. If

		Olórun grants us success, we'll treat it. And there are some, there's no amount of effort that will heal him completely. Do you understand? He won't be completely healed.
19.		Interviewer: Could you elaborate on the things that give rise to 'mental' problems?
20.	• Identifies what gives rise to mental illness • Alludes to breakdown of a sacred order as principal factor • Alludes to inheritance (not necessarily biological) from parents as cause of mental illness	Interviewee: Do you mean madness [wèrè]? Yes, there are many things. Like I said, some people think too much. Some people, it is smoking marijuana. For some, people are cursed. Some people are being 'done' to by others! There are some where the father suffered the same illness. As the father slept with the mother, it is compulsory that the child becomes… [awaiting a response from the interviewer]?
21.		Interviewer: The child becomes mad.
22.		Interviewee: Yes. Whatever you don't understand, make sure you ask me!
23.		Interviewer: Okay, sir. In a year, about how many 'mentally challenged' men are brought to you?
24.		Interviewee: In a year?
25.		Interviewer: Yes.
26.	• Non-formality of practice and fluid professionalism	Interviewee: Ah, it is God that [blesses]! I can't know an exact figure, however…
27.		Interviewer: Alright, so you don't have a particular figure, perhaps in a month, you have…
28.	• Does not accommodate clients	Interviewee: In a month, sometimes, we have up to five people, but I don't house them…
29.		Interviewer: You don't house them.

30.		Interviewee: I'll only collect the money for the treatment and treat them and then let them go.
31.		Interviewer: Alright, so you've worked on everyone that has come and they've all become well?
32.	• Asserts previous successful interventions	Interviewee: Yes.
33.		Interviewer: Alright, so if someone is brought to you now for treatment, what is the process you'll undertake in healing the person?
34.		Interviewee: I'll perform a ritual after which I'll ask them to pay for the ritual. Sometimes they pay N3500. I'll then my assistants to begin the work for free. Once the person is well, he goes.
35.		Interviewer: Have you worked on anyone that didn't get well?
36.		Interviewee: Ah!
37.		Interviewer: That didn't work. They didn't get well.
38.	• Asserts limitations in effecting healing • Highlights dependence on sacred entities	Interviewee: That didn't get well. If a mad person is brought, and I can't do it…I'll say I can't do it; if I can, then I'll say I can, and I will and God will take control. However, anyone we work on that we see is about to go sour, we'll quickly…[moves around cowries on his table].
39.		Interviewer: So has there been anyone that they brought to you and you recognized that the case was too hard? Does Ifá tell you?
40.	• Consults with configurations in	Interviewee: Yes.

	cowries	
41.		Interviewer: So there are no particular ways or symptoms to determine severity or duration?
42.	• Affirming his experience and expertise • Asserting his authenticity	Interviewee: I'll know the difference; I'll know when nothing is wrong and what is happening.
43.	•	The people brought here for treatment – must they believe that what you're going to do is going to work?
44.	• Olórun heals	Interviewee: By the power and grace of Olórun.
45.		Interviewer: We mean: Is their belief what will make it [their healing] work? And if they don't believe, it may not work, it will not work.
46.	• Affirms participation of clients as efficacious in healing	Interviewee: Yes.
47.		Interviewer: Thank you, sir. That's all we want to know.