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Ancestral calling, traditional health practitioner training and mental illness: An ethnographic study from rural KwaZulu-Natal, South Africa

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Abstract

This qualitative ethnographic study complements an epidemiological study on first episode psychosis in Vulindlela, a rural area in KwaZulu-Natal, South Africa. It focuses on two themes that emerged from our data: (1) the calling of the ancestors to become a traditional health practitioner and (2) *ukuthwasa*, the training to become a traditional health practitioner. The purpose of this study is to describe the ancestral calling, and to explore whether *ukuthwasa* may help with the management of mental disturbances, including unusual perceptual experiences. We also provide a discussion of the changing sociopolitical context of healing in KwaZulu-Natal, as a background to our study. In-depth interviews were conducted with 20 (apprentice) traditional health practitioners, formal health practitioners, patients and relatives recruited through local traditional health practitioners and a health care clinic. Our results show that the ancestral calling might announce itself with symptoms of mental illness including unusual perceptual experiences, for which some participants consider *ukuthwasa* as the only effective cure. We found indications that in some individuals successful completion of *ukuthwasa* might promote recovery from their illness and lead to a profession in which the unusual perceptual experiences become a legitimate and positively valued aspect. We suggest that – in this particular community today, which has been subject to several sociopolitical changes – *ukuthwasa* may be a culturally sanctioned healing process which moderates experiences that a Western psychiatric system might characterize as psychotic symptoms, providing some individuals with a lucrative and respected role in society.

Keywords

ancestral calling, mental illness, traditional health practitioner, culturally sanctioned intervention, sociopolitical context, South Africa

Introduction

A growing body of evidence suggests that cultural factors and religious beliefs might affect the lived experience, epidemiology, as well as the course and outcome of hallucinations and psychotic disorders (Al-Issa, 1995; Bauer et al., 2011; Burns, Jhazbhay, Esterhuizen, & Emsley, 2011; Dein & Littlewood, 2011; Harrison et al., 2001; Jablensky et al., 1992; Kovess-Masfety et al., 2018; Lim, Hoek, & Blom, 2015; Lim, Hoek, Ghane, Deen, & Blom, 2018; Luhrmann, 2017; Luhrmann, Padmavati, Tharoor, & Osei, 2015; Susser & Wanderling, 1994). In research on psychosis, an ethnographic approach is essential to understanding how unusual perceptual experiences that would be recognized by secular observers as hallucinations, are identified, understood and treated by members of a particular society (Laroi et al., 2014; Myers, 2011).

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To explore today's concepts and pathways to care in South Africa in relation to mental disturbances, including unusual perceptual experiences, we conducted an exploratory ethnographic study at sites of traditional health practices and at a local clinic in KwaZulu-Natal (KZN), South Africa. This qualitative study complements an epidemiological study of first episode psychosis in Vulindlela, a rural area in KZN (Psychotic Disorders in an African Setting: Incidence, Early Course and Treatment Pathways; FEP-INCET study; Veling et al., 2019). During fieldwork, one of the explanations that was given by the participants for unusual perceptual experiences and other mental disturbances, was the "calling of the ancestors to become a traditional health practitioner (THP)[1]." Individuals diagnosed by THPs as experiencing ancestral calling, were advised to start *ukuthwasa*, the training to become a THP (see also glossary of isiZulu[2] terms, available online).

Various publications report on the ancestral calling and *ukuthwasa* among the Nguni, to which the Zulu belong (Buhrmann, 1982; Edwards et al., 1983; Ensink & Robertson, 1996; Lamla, 1975; Lee, 1969; Mlisa, 2009; Ngubane, 1977; Niehaus et al., 2004; Shezi & Uys, 1997; Sorsdahl, Flisher, Wilson, & Stein, 2010). In this literature, the term *ukuthwasa* is often used to refer to calling-related signs and symptoms, rather than to the training process of becoming a THP. In addition to this etymological ambiguity, there is no consensus about whether the calling should be regarded as pathological. The biomedical literature tends to construe the ancestral calling as psychopathology (Edwards et al., 1983; Ensink & Robertson, 1996; Niehaus et al., 2004; Shezi & Uys, 1997; Sorsdahl et al., 2010), whereas anthropological literature suggests a benign form of spirit possession, which legitimizes an improved socio-economic position via entry into the THP network (Lee, 1969; Ngubane, 1977). The literature on *ukuthwasa* as a healing process is sparse and dates back to four decades ago. Only a few scholars have described the training to become a THP as an intervention for psychopathology (Buhrmann, 1982; Lamla, 1975).

The present article describes the ancestral calling and *ukuthwasa* within the contemporary context of the health care system in Vulindlela, a rural Zulu community in South Africa. We aim to shed light on the manifestations, diagnostic process, treatment process and local interpretation of the ancestral calling from an emic perspective, and to explore whether *ukuthwasa* has the potential to influence the course of unusual perceptual experiences and other mental disturbances. We also make inferences as to how the calling and *ukuthwasa* might be interpreted from an etic, psychiatric point of view. In addition, we provide a discussion of sociopolitical context, as the role of illness and of both Western and traditional health practitioners is seen as continually being redefined in relation to political and economic changes and the institutions of the state (Baer, Singer, & Susser, 2013; Hirsch et al., 2009; Susser, 2009).

Sociopolitical context of healing in KwaZulu-Natal

KZN, with 11.07 million people, is the province with the second largest population in South Africa (Stats SA, 2016). Our study site, Vulindlela, is a rural area situated in one of the former so-called "homelands" or "bantustans," previously called KwaZulu and now part of the Province of KwaZulu-Natal, where Zulu people were forced to live by the apartheid government to enforce segregation. Nowadays, Vulindlela is designated communal land under the control of a trust managed by the Zulu King, a subordinate hierarchy of chiefs, and the civic administration of KZN. This situation was negotiated in sometimes violent struggles for political representation, leading up to and following the first democratic election in 1994. In KZN, the Inkatha Freedom Party or IFP, which is dedicated to revitalizing the historical roots of the Zulu and which is concentrated in the communal areas of the Zulu Kingdom, was in competition with the African National Congress (ANC) concentrated in the urban areas, which, although dominated numerically by Africans of Zulu origin, believed in a secular, universalist political approach. Since circular work migration and extended families split between the rural and the urban areas have been common in KZN, the distinction between the Kingdom and the urban informal settlements was blurred and characterized by splits and political divisions over territorial rights for generations. The country's changing political situation has deeply impacted the healing context in KZN, as traditional healing was originally vilified by colonial and later apartheid governments, emphasized and promoted by the IFP and then accepted more recently by a more politically and culturally complex ANC majority government (Susser, 2009).

Although Western biomedical explanations and treatment for illness and disease have been accepted over the past centuries, beliefs in supernatural powers as explanations for illness and misfortune are also widespread (Burns, Jhazbhay, & Emsley, 2011; Edwards et al., 1983; Ensink & Robertson, 1999). The complex interaction of Western medicine, religion and local praxis has been analyzed extensively (Comaroff & Comaroff, 2000; Geschiere, 1992; Lindenbaum, 2013; Susser, 2009). In many situations, a spiritual worldview and reliance on THPs has been revitalized to meet contemporary challenges, such as HIV/AIDS

(Comaroff & Comaroff, 2000; Geschiere, 2010; Susser, 2009). Research suggests that poverty as well as high rates of HIV, which co-exist with insufficient treatment and confused Western and government HIV messaging, reflected in the government denialism about HIV up until 2008, have contributed to a resurgence of belief in local, traditional and alternative healing practices, and a rise in status of THPs in both urban and rural areas of South Africa (Ashforth, 2000, 2005; Delius, 1996; McGregor, 2007; Steinberg, 2008; Susser, 2009). According to a recent estimation there might be around 200,000 THPs in South Africa (Ramgoon, Dalasile, Paruk, & Patel, 2011). People often seek help from both THPs and formal health services (Burns & Tomita, 2015; Green & Colucci, 2020; Labys, Susser, & Burns, 2016).

During the early 2000s, the South African Government made political decisions regarding the official empowerment of THPs. In some cases, this related to the controversy over the recognition of HIV (Susser, 2009) and was implicated in the ongoing negotiations of the ANC with the traditional Zulu leadership in KZN. Another aspect of this process of state recognition was the passing of the Traditional Health Practitioners Act in 2007, which aims to regulate THPs so as to incorporate them into the national health care system. These and other rulings not only empowered THPs, but reinforced traditional provincial leadership in KZN. Nowadays, in KZN there are three large organizations of THPs with significant representation in the Zulu communal region. Thus, this research was carried out in a district in which the status and economic opportunities for THPs are increasing, and the role of THP offers legitimacy and access to powerful networks, within a changing political arena.

Methods

The current study complements an epidemiological pilot study, entitled *Psychotic Disorders in an African Setting: Incidence, Early Course and Treatment Pathways (FEP-INCET)*, designed to develop a method for screening, identification, and follow-up of individuals with incident psychosis within a rural, low-income South African setting (Veling et al., 2019). The ethnography was built on previous fieldwork conducted intermittently in the region since 1992 (Susser, 2009).

Setting

The study was conducted in Vulindlela, a poor rural community in the Msunduzi Municipality in KZN, that is situated approximately 150 km north-west of Durban. Vulindlela has about 250,000 mainly Zulu-speaking residents and five traditional councils or tribal authorities, each headed by an *Inkosi* (tribal chief). The tribal chiefs play a key role in the implementation of public services, including infrastructure, health and education, in parallel with formal government authorities (Labys et al., 2016). Unemployment rates are high and per capita income is low (Hlongwa & Wet, 2019). Work is mostly available through local infrastructure projects or in nearby towns. Most men and many women live and work in the cities during the week, returning to rural homesteads on weekends (Van Rooyen et al., 2013). Families, particularly women, including THPs, maintain small gardening plots and rear domestic animals in their backyards. KZN has the highest HIV prevalence in the country, with 60% of the women and 40% of men in the age group 25–40 years (De Oliveira et al., 2017). Vulindlela has nine public sector primary health care clinics (Labys et al., 2016) and the nearest psychiatric referral hospital is Town Hill psychiatric hospital in Pietermaritzburg.

Participants

Traditional and formal health care workers, patients with mental disturbances and other community members who had any experience with mental illness were recruited via local traditional health practices and a health care clinic, in order to include both aspects of the contemporary healing context. First, the researcher responsible for community liaison and project management (co-author EM), a bilingual psychiatric nurse with Zulu identity, widespread connections among Zulu leadership, and extensive knowledge of Zulu cultural processes, traditional healing practices and psychiatry, identified a key informant THP ($n = 1$). Both this key informant and the project manager introduced the researchers to the local community and identified potential participants. Via snowball sampling we included other THPs ($n = 5$), apprentice THPs ($n = 3$), acquaintances and family members of THPs ($n = 8$), as well as patients suffering from mental disturbances as identified by the THPs ($n = 3$).

Second, the project manager introduced the researchers to a local health care clinic, where we interviewed a convenience sample of formal health practitioners ($n = 2$) and patients ($n = 5$). To understand unusual perceptual experiences, we asked the clinic's primary care physician to refer patients to us who were (a) taking antipsychotic medication, and (b) psychiatrically stable enough to participate in the interview. All referred patients had a diagnosis of "psychotic disorder" or "schizophrenia" written in their patient files, assigned to them after examination at a psychiatric hospital in Pietermaritzburg.

All the traditional and formal health practitioners, patients and community participants were living in the research area and spoke isiZulu[3], except for the primary care physician who was a white South African man who had been working in the area for decades. They were all 21 years or older.

Ethnographic fieldwork and interviews

We conducted our ethnographic study between May and August 2013. The ethnographic team was comprised of the first author[4], the senior author[5], a skilled bilingual (isiZulu and English) Zulu-identifying interpreter who is working as a THP herself[6] and two bilingual Zulu-identifying research assistants (RAs).

The fieldwork consisted of semi-structured in-depth interviews and participant observation. It was conducted by the first author and the interpreter; some interviews were also attended by the last author. We introduced ourselves as "university researchers interested in learning more about local explanations and treatments for mental disturbances." We asked open-ended questions to explore any mental disturbances the participants had personally experienced or knew about concerning anyone in their community, the causes ascribed to these disturbances, where help was sought and what kind of interventions applied. In most of the first interviews, the ancestral calling and *ukuthwasa* were mentioned, which then, based on an emergent design approach (Creswell, 2007), became structural topics of our interviews. If a participant brought up the ancestral calling in relation to mental disturbances voluntarily, planned probes included experiences related to the calling and the function, course and treatment of the calling. If the ancestral calling was not mentioned, we specifically asked for any experience with the ancestors. In total, the sample for the ethnographic study consisted of 27 participants. In three out of 27 participants, issues of the ancestral calling were not addressed during the interviews. All three were patients who visited a THP's practice because of mental disturbances, and they explained their disturbances in terms of HIV, domestic violence or a combination of alcohol and evil spirits. Four out of 27 participants, all acquaintances of a THP, stated that they had no personal experience with the ancestors and they did not make any statements about the calling and *ukuthwasa*. These seven participants were excluded from the analysis. Overall we spoke with 20 out of 27 participants about the ancestral calling and *ukuthwasa*. Consequently, the present report is based on the data that derived from these 20. See also Table 1.

Interviews lasted between 20 minutes and two-and-a-half hours. Some participants were interviewed more than once. For 17 out of 20 informants the interviews were in isiZulu, three were in English. Formal interviews were audio-recorded, transcribed verbatim by one of the RA's and translated into English by the other RA, who was familiar with both isiZulu and English psychological terminology. Participants' names have been anonymized. At all times during the fieldwork, privacy was assured. Three out of six THPs received remuneration for mobile phone costs, since we asked them to call us when they were seeing patients with mental disturbances. All participants provided verbal, audio-recorded informed consent in isiZulu or English after they had been informed about the study and procedure.

Participant observation was the core method in studying behavior, gestures and symbolic activities, such as rituals and ceremonies. Notes were taken to document conversations and non-verbal signs and gestures. On three occasions, the first author resided for 2 to 4 days at the home of our key informant

Table 1. Overview of participants of whom the interviews included the themes of the ancestral calling, *ukuthwasa* and/or communication with ancestors ($N = 20$).

Included via	Participants	Male	Female	Total
Traditional health practices (snowball sampling)	THPs	2	4	6
	Apprentice THPs		3	3
	Acquaintances of THPs (1 sister, 1 brother, 1 neighbor)	1	2	3
	Wife of patient		1	1
Health care clinic (convenience sampling)	Primary care physician	1		1
	Nurse		1	1
	Patients on antipsychotics	2	3	5
	Total	6	14	20

THP: traditional health practitioner.

THP to observe her in her daily activities, including her consultations with patients and an initiation ceremony of one of her students.

The study was approved by the chairperson Zulu chief and his Traditional Council. Ethical approval was obtained from the University of KwaZulu-Natal Biomedical Research Ethics Committee (file number BEO68/11) and Columbia University Institutional Review Board (file number IRB-AAAI1536).

Data analysis

During the data collection, the first and last author individually analyzed the data from the transcripts and field notes and highlighted phrases signifying relevant concepts, beliefs, behaviors and attitudes. Codes were written in the margins of the transcripts, and compared across transcripts to identify recurring themes that were subsequently categorized. Next, extracted themes were compared and discussed between the first and last author. During ethnographic data collection, themes evolving around the ancestral calling and *ukuthwasa*, namely the association between mental disturbances and local healing processes, as well as the other early ethnographic findings, were discussed among the first and senior author and presented by the first author at a meeting of the FEP-INCET study in Durban. After extensive discussion, the collaborators, including all co-authors, agreed to include the ancestral calling and *ukuthwasa* as structural topics in the remaining interviews, and to write a report on these concepts specifically.

Results

This article discusses the ancestral calling to become a THP and the training process, *ukuthwasa*, from the perspective of three different groups of participants: (1) participants recruited via THPs; (2) formal health practitioners from a local health care clinic; and (3) patients who were prescribed antipsychotic medication via a local health care clinic. Based on the interviews with the participants recruited via THPs, four key themes were identified in the data in relation to the ancestral calling, namely: the manifestations, diagnostic process, *ukuthwasa* and local interpretation. These themes are presented first, followed by the perspectives of the health practitioners and patients from the health care clinic.

Findings from participants recruited via THPs

Manifestations of the ancestral calling. According to the (apprentice) THPs, the calling of the ancestors to become a THP involves accidents and misfortune, a range of physical symptoms and various mental disturbances. THP #2 puts it as follows:

> Some [individuals with the calling] come with lots of problems in their lives, some are sick ... and they lose weight. And for some, ancestors speak to them until it is like they are mentally disturbed. And some cannot find a job or cannot have children.

The physical symptoms most commonly related to the calling, are: (severe) headache, stomachache, burning feet, back pain, loss of appetite, fatigue, palpitations and fainting. In every individual they occur in variable sequence, frequency and seriousness. According to the participants, often no diagnosis was found when a health care clinic or hospital was consulted about these symptoms.

Participants mentioned the ancestral calling as a possible cause for mental illness. According to the (apprentice) THPs, every *ithwasa* (apprentice THP who has received a calling of his or her ancestors to become a THP and who is undergoing the process of *ukuthwasa*), sooner or later, hears voices. Usually, the voices are heard through the ears and imperative. *Ithwasa* #2 started to hear voices 3 years ago "deep down in her ears, as if there were many people talking in my ears." She describes:

> I was really confused my ancestors will come to me, my grandmother would come and speak to me and tell me what she wants. ...I started crying out loud and I started singing. ... People were just confused because I was talking to a dead person during the day.

All (apprentice) THPs told us that they had certain visual experiences as well, often in the form of visions. *Ithwasa* #1 gives an example:

> ...it was like there is a shadow passing through my eyes, not like someone was walking in the door, but just like this...passing...She was walking on her stomach [like a snake].

Also, unusual somatosensory experiences occur as part of the calling. Our key-informant, THP #1, suffered from the feeling that something was "moving" through her abdomen, for which she visited the hospital: "that thing would go around and around...they can't find nothing [at the hospital]." Another sign of the calling are vivid and prophetic dreams, through which they often receive messages. THP #1 told us that during *ukuthwasa* her deceased grandfather told her in a dream to meet at the sea. Subsequently, she took off for the sea and brought some people with her. When she arrived, she saw the sea opening up for her:

> I was so scared. ...Then I went in [the sea],...I climbed on a tree, the wave brought a tree for me to climb on and it took me down under, and that's where my grandfather was....In there they braided my hair, took out *imithi* [traditional medicines], the bag and the bones [from small animals and shells, used by some THPs for diagnostic purposes].

Under the water, THP #1 had a conversation with her grandfather. She is convinced that her experience was not a dream: "it really happened! There were other people who have seen it [the sea splitting]."

At onset, voices and other unusual experiences as well as the content of dreams may not be recognized by the individual. This results in confusion, anxiety, fear of "losing their mind", sleeping problems and other signs of mental illness. *Ithwasa* #2 said: "It took one week when I was seriously sick and I was beginning to lose my mind", and "I was scared because the dead people that I was seeing for the first time were there, and I was thinking I will never be alright the way things were happening." *Amathwasa* (apprentice THPs) as well as mature THPs fear negative consequences if they do not obey the orders they receive through the voices and dreams. Although less common, aberrant behavior was reported by four of the six THPs and one *ithwasa* as a consequence of the calling, such as screaming, throwing things, running around aimlessly and singing or speaking incomprehensibly. *Ithwasa* #2 described a patient she had seen together with the THP where she was in training and who they had diagnosed with the calling: "... [he] would just scream, cry loud, jump up and down and want to run away...to the river."

Calling-related mental disturbances, together with somatic symptoms, are experienced as serious illness, which causes major distress and is recognized as illness by others. Four THPs and all *amathwasa* told us that their illness dramatically affected their daily functioning.

Diagnostic process. Somatic symptoms were often the initial motive for seeking help, although more severe mental disturbances could sometimes be the primary reason. Most participants tried Western health facilities first but were unable to find relief. Then they visited a THP. A few participants went to a THP from the start.

The THPs explained that when an individual is hearing voices, they need to distinguish whether these are "good" voices, ostensibly deriving from ancestral spirits, or "bad" voices associated with evil spirits. When asked how a THP can distinguish between the two, THP #3, said: "Ancestors will never say wrong things like killing a person, they cannot come with weapons and threaten to kill you." The THPs said that people with mental disturbances who hear evil spirits, suffer from *ukuhlanya* (madness), which can be caused by various local syndromes, such as *izizwe* and *amafufunyana*, but also by causes such as infectious diseases, substance abuse or stress. Although people suffering from such evil spirits are said by the THPs to present far more often than *amathwasa* with aberrant and/or violent behavior and bizarre thoughts, the THPs did not always find it easy to differentiate between the two. However, through prophecy and the help of their own ancestors, THPs believed they could often diagnose an individual correctly.

Ukuthwasa. When the calling is recognized as cause for the illness, the only effective treatment according to participants is *ukuthwasa*, or "*thwasa* training" (THP #5). (Apprentice) THPs explained *ukuthwasa* as an integral treatment of the mental and physical disturbances and training to become a THP, which begins after the acceptance of the calling. *Ukuthwasa* is followed with a THP, regarded as their "mother" or trainer. The participants tended to do *ukuthwasa* outside their own district fearing the local stigma of mental illness. They explained that this stigma is much more related to their (yet untreated) mental state, than to the process of becoming a THP.

During *ukuthwasa*, the apprentice THPs are treated with *imithi* and attend rituals for sacrificing and offering, where they dance, sing and drum. Their trainer teaches them to interpret what their ancestors are saying and to manage the voices as communication, rather than a distressing symptom. The ancestors reveal information, for example about traditional medicines, through dreams and voices, and the role of the trainer is to give detailed explanation and guidance. According to the *amathwasa* and THPs, these are the ways their ancestors tell them the diagnosis and treatment for their patients. During *ukuthwasa* the apprentices assist their trainer while she is seeing and treating patients and are taught how to convey messages from the ancestors to the patients, how to conduct rituals and where to find *imithi*.

According to the THPs, the majority of the individuals who start *ukuthwasa* are very ill. Improvement is often noticeable within 1 week after starting *ukuthwasa*. Thereafter, their health gradually improves; the physical symptoms more rapidly than the mental disturbances. Over time as *ukuthwasa* progresses, confusion and anxiety usually disappear, as well as experienced distress and dysfunction owing to the perceptual experiences. All THPs and two *amathwasa* who were further in the process, explained that the graphic dreams and auditory and visual experiences in the form of voices, sounds and visions usually persist indefinitely as they intercede with the ancestors as part of their healing

profession. The content and speed of this treatment/training process is continuously adjusted to the health of the apprentice, and may last from months to several years. If *ukuthwasa* is successfully completed, an initiation ceremony follows as the apprentice is inaugurated as a THP. According to the participants, practicing THPs are usually well-functioning individuals with no signs of mental illness. We noticed that at least five out of six THPs were well-known, frequently visited and highly respectable figures in their village with high social standing.

The THPs also noted that there are individuals who do not respond to *ukuthwasa*. In these cases, *ukuthwasa* was terminated and the diagnosis revised – often to *ukuhlanya* (madness). If *amathwasa* drop out during the process or if their ancestors are discontented for whatever reason, they believed that the illness would aggravate and/or recur. Participants unanimously insisted that denial of ancestral calling and refusal or postponement of *ukuthwasa* and functioning as a THP, results in an aggravation of illness and misfortune, and can even result in death as ancestors might withdraw their protection from a disobedient individual. A summary of this process can be found in Figure 1.

Local interpretation of the calling. According to participants, when someone is being called by ancestors to become a THP, this person is possessed by ancestral spirits. In general, ancestral calling is regarded as a gift, despite the hardships, symptoms and disturbances that accompany the calling at the onset. According to (apprentice) THPs, the illness and hardships are caused by ancestors for three reasons. The first is to attract attention. THP #3 said:

> ...If the person keeps getting sick, it is because the ancestors want to talk, they want you to prepare some *imithi* for them or holy water so that they can talk clearly and you can hear what they are trying to say.

The second reason is to make their descendants accept the calling to become a THP. A worsening of symptoms and traumatic experiences for instance, were commonly explained as messages from the ancestors to exert pressure on the individual called to start *ukuthwasa*. For example, THP #5 believed that her ancestors had withdrawn their protection from her son, which eventually resulted in his death, and this was her ancestor's most powerful sign that she needed to accept her calling. The third reason is that calling-related experiences are seen as necessary to become a good THP. *Ithwasa* #2 said: "when you see a person suffer from the same thing you suffered, you don't have a problem because you know it's just ancestors and there is nothing to be afraid of."

At least one *ithwasa* and three THPs mentioned family members who were THPs. THP #5 believed the calling was hereditary. Despite the fact that being a THP usually involves a source of income and a high(er) social status, participants suggested that having the calling is not desirable for most people. The acquaintances of THP #3, who accompanied her

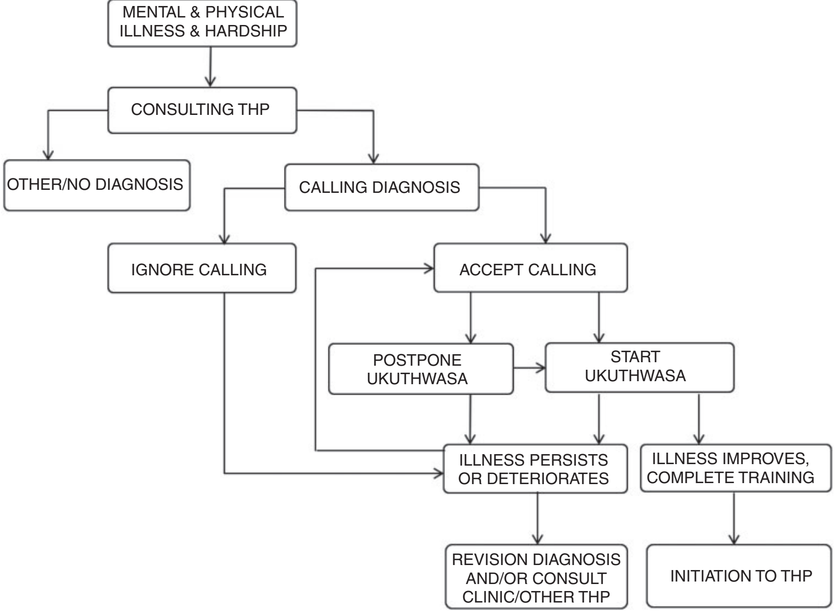

Figure 1. Schematic overview of the course of calling-related illness.

during the interview, answered with a firm "no" when they were asked whether they would like to be able to communicate with their ancestors too. A fearful sister remarked:

> I'm afraid because the ancestors are a special gift that you will have ancestors and you will work like this. ... Ancestors choose some people that will follow them, not just anyone, they just chose one person and say this one is going to help the community.

Findings from participants recruited at the clinic

Perspectives of formal health practitioners. One nurse and one primary care physician were interviewed. The nurse recognized that some patients talk to their ancestors and attribute their illness to them:

> Personally, I usually say: maybe it is because of mental illness, because I do not believe in *amadlozi* [ancestors] me myself. It is not that I am judging a person but I do not believe an *idlozi* [ancestor] can talk to you. Maybe in a dream ... but ... just, during the day and you're talking to yourself and you say you are talking to *amadlozi*, I don't think mentally you are OK.

She was also consulted by THPs at the clinic, who presented themselves with mental illness, which they understood as the calling of the ancestors. In her opinion, some of these patients might suffer from hallucinations or even a psychotic disorder. For some she prescribed antipsychotics: "Most of them, when you assess in your [psychiatric] way, you can see maybe he is schizophrenic, it is only that he is not taking treatment." On the other hand, she recognized the value of THPs:

> We understand that our patients believe mostly in the traditional healers. So we work together, if they bring the patient here we accept the patient. ... It is their [the patients'] belief, if he believes that the traditional healer can help him, he's allowed to go wherever.

The primary care physician explained that patients who hear voices, often think it is their ancestors. According to him, individuals who are believed to have the calling are experiencing mental symptoms more often than not. These mental symptoms are reported more frequently by apprentice THPs than by mature THPs. However, he said:

> I have seen quite a few [patients] with *ukuthwasa*. ... *Ukuthwasa* patients do not usually present with psychiatric symptoms, they come with something else. ... With physical symptoms. Like the patient we saw, that worm creeping up in the stomach towards the chest, chest pain, headaches, yeah, strange physical symptoms.

Patients whom he saw who were doing *ukuthwasa* were usually in their twenties. The youngest was 16 years old, and most were female. About *ukuthwasa*, the physician said:

> They usually start dressing as *izangoma* [diviners] then, with the beads and everything ... if they have a problem, I mean it really is a problem for them, because their life is completely turned upside down, because they often move away from home, they move in with a mentor ... and if they have a psychiatric illness at that time, it is very difficult to treat.

He had also seen very ill patients who did *ukuthwasa* and who came back cured. When asked how he would explain that, he answered: "How would you explain psychoanalysis. ... I would say it is aligning with all the cultural expectations and difficulties."

Perspectives of patients using antipsychotic medication. The five patients had all been prescribed antipsychotic medication because of a psychotic disorder. All five had consulted or were still consulting THPs and four had been admitted to a psychiatric hospital at least once. Three of the patients (all female) had heard ancestral voices; one was not sure whether the voices were from ancestors. Patient #1 had never heard ancestral voices, but he had spoken to his ancestors and found that they were listening "through their actions." The diagnoses from the THPs whom they visited, were: ancestral calling in two out of five cases (both female); ancestral punishment because certain rituals had not been performed in two cases (one male, one female); and "fits" in one case (male). One of the two patients who were diagnosed with the calling, thought this explanation was "nonsense" and a "lie" and never started training (patient #4). Patient #5 had undergone *ukuthwasa* for a while. She was given *umuthi* by the THP, which made her feel better, but she did not succeed. Later, she was admitted to a psychiatric hospital. Asked whether she believed that she would have been cured if she had become a THP, she answered:

> I don't know, I thought they will help me but then I did not have anyone to pay for my graduation. I would be an *isangoma* by now, I don't know if they will still allow me to continue.

Discussion

Our qualitative findings from a Zulu communal district suggest that a certain set of mental disturbances, including unusual perceptual experiences, might be locally explained as the ancestral calling to become a THP. At the onset of the calling, the unusual perceptual phenomena, most often in the form of hearing voices, are experienced as disturbing and distressing, and are usually recognized as part of an illness by the individual, their relatives and by both traditional and formal health practitioners. After successful completion of *ukuthwasa*, the perceptual experiences are still present, as THPs are believed to diagnose and treat patients via communication with their ancestors. However, they have become positive skills serving as the professional tools of THPs, and they no longer cause distress.

Conceptualization of the ancestral calling

There are various ways the calling and related unusual perceptual experiences, or hallucinations, can be conceptualized. First, the calling might reflect no psychopathology, but rather culturally bound reactions generated by complex stress or motivational issues. THPs and other participants we recruited via THPs came to understand the calling-related signs and symptoms as a cultural illness caused by an inherited gift from the ancestors to the person who is supposed to become a THP. For them, the calling-related hallucinations are understood as contacts with the ancestral spirits – and not as madness – as long as the individuals' experiences match the cultural expectations of the calling, although these individuals often did not know about their calling at the time they were seeking help. An anthropologist of Zulu identity, Harriet Ngubane, described the ancestral calling, in the 1960s, as a benign form of spirit possession and not as an illness per se (Ngubane, 1977). She contrasted this with evil spirit possession or possession by alien spirits from outside the lineage. Mlisa, a Xhosa-identified psychologist as well as a diviner, argues that the hardships and symptoms that diviners experience during the process "cannot be seen as symptoms of disease in the medical sense but crises of evolution of consciousness. . . . Crises serve as a means of helping women construe their healing identities during their training" (Mlisa, 2009: 231). Possibly some persons may want to become THPs and declare culturally relevant symptoms such as hallucinations in order to enter *ukuthwasa*. Previous anthropological literature has suggested that the ancestral calling is the only way for Zulu women to escape an unequal, patriarchic society, leading to an improved health status, economic gain and gaining an authoritative position in society (Hammond-Tooke, 1989; Lee, 1969; Ngubane, 1977; Ogana & Ojong, 2015). There are far more female than male diviners among the Zulu, with an estimated ratio of 9:1 (Ogana & Ojong, 2015), which is also reflected in our limited sample. However, this may change in South Africa, as the financial benefits of being a THP seem to lead to more self-appointed male THPs (Ogana & Ojong, 2015). Nevertheless, our results also indicated that most people in KZN do not want to receive the calling because of the hardships, symptoms and the intensive training away from an individual's home (Hammond-Tooke, 1989; Mlisa, 2009). Another non-psychopathological possibility is that the *amathwasa* are a selected group of individuals who represent healthy voice hearers. It is estimated that approximately 15% of the healthy population hear voices at times (Beavan, Read, & Cartwright, 2011). When compared with persons with psychosis, auditory hallucinations of healthy voice hearers usually have less negative content, shorter duration, lower frequency, less distress and disruption of daily life and more controllability, and the voices are more frequently attributed to spiritual or religious sources rather than to real people (Baumeister, Sedgwick, Howes, & Peters, 2017; Daalman et al., 2010; Luhrmann, 2017). However, our qualitative results suggest that at the onset of the hallucinations the apprentice THPs usually do experience distress, dysfunction and no controllability.

The second concept is that the calling-illness reflects culture-specific psychopathology that is not (yet) recognized by psychiatric taxonomy. According to Shezi and Uys (1997), the calling-illness among the Nguni shows similarities with shin-byung. Shin-byung is a cultural syndrome originating from the Korean shamanistic tradition. This syndrome, which was included in the fourth edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR) but not in the subsequent fifth edition (DSM-5), is the possession from a god that a chosen healer goes through, and that is accompanied by physical pain and psychosis that may only be cured through acceptance of and full communion with the spirit (Yi, 2000).

The third concept is that the calling illness resembles psychopathology, such as a clinical high-risk state for psychosis, an actual psychotic episode or possibly some kind of dissociative state. Our findings show that calling-related hallucinations often start with other signs of mental disturbances, such as confusion, anxiety, fear of "losing their mind" and sleeping problems, resulting in distress and impaired functioning, and which may run in certain families. This presentation is quite similar to the presentation of patients with early psychosis as seen in Western psychiatric facilities. Despite the nonspecific somatic symptoms that might occur concurrently, there

are insufficient indications for an underlying somatic disorder, and we found no indications that the mental state of individuals with the calling was substance induced. The health practitioners from the local clinic whom we interviewed, placed the calling illness in the context of psychosis, and they sometimes prescribed antipsychotic medication to apprentice and mature THPs. In addition, of the five patients with a psychotic disorder whom we interviewed, two had been diagnosed with the ancestral calling by THPs. This psychopathological interpretation is congruent with the biomedical literature, that has construed the ancestral calling among the Nguni most often within the context of psychotic disorders (Edwards et al., 1983; Niehaus et al., 2004; Shezi & Uys, 1997; Sorsdahl et al., 2010) and, to a lesser extent, within the context of mood disorders (Ensink & Robertson, 1996; Shezi & Uys, 1997). For example, Sorsdahl et al. (2010) showed that 40% of 50 interviewed South African THPs identified the symptoms described in a schizophrenia case vignette as the ancestral calling to become a THP. Ensink and Robertson (1996) reported various similarities between ancestral calling and mixed anxiety and depression as seen in Western countries. Niehaus et al. (2004) found that nine out of 200 (4.5%) Xhosa schizophrenic patients had been previously diagnosed with the calling by THPs, and stated that the calling may herald the onset of schizophrenia. Shezi and Uys (1997) showed that seven out of 40 patients admitted to a psychiatric ward explained their illness as the ancestral calling, of whom three were diagnosed with schizophrenia, three with mood disorder and one with delusional disorder based on the DSM-IV. In an older study, Edwards et al. (1983) found that Zulu-speaking patients diagnosed with psychotic illness commonly ascribed their psychotic symptoms to the calling of their ancestral spirits. The latter three studies were centered on patients diagnosed in Western terms or who were admitted to a psychiatric ward. It is possible that individuals who became successful THPs were underrepresented in the analyses.

In a subsequent epidemiological study, we have examined the manifestations of the ancestral calling among a group of apprentice THPs from a psychiatric diagnostic perspective. This article is in press with *Transcultural Psychiatry* (Van der Zeijst et al., in press).

Conceptualization of ukuthwasa

Ukuthwasa is an old practice that is embedded in the Zulu history of traditional healing. However, the sociopolitical context in which *ukuthwasa* takes place has changed since the formation of the new South African state and certain traditional beliefs seem to have been revitalized (Comaroff & Comaroff, 2000; Geschiere, 2010; Susser, 2009). Although some of our informants were skeptical about the notion of ancestors, our data suggest that in the absence of other effective treatments, local residents with psychological disturbances tend to explore the possibilities of traditional healing. Participants from the formal health care setting confirm that some patients under Western care have consulted THPs. In addition, the physician and nurse confirmed that some THPs have been prescribed biomedical treatments – showing that it is not a question of "traditional erosion" or exotic beliefs, but rather a pragmatic approach to the experience. Under contemporary conditions, THPs have become more established; allowing for a strategic niche that in itself has given a new image and economic basis to the whole training process.

Our participants recruited via THPs regarded *ukuthwasa* as both the apprenticeship to become a THP and the only effective treatment process for calling-related mental and physical symptoms. The physician also acknowledged *ukuthwasa* as a potentially effective treatment for certain types of mental illness, while the patients with psychotic disorder were more ambivalent. Becoming a THP has disadvantages, and some people adhere to the biomedical model of disease rather than to a more traditional and spiritual model. Therefore, it is not surprising that not everyone regards *ukuthwasa* as a preferred process.

Based on our findings, it is during *ukuthwasa* that experienced symptoms, including hallucinations, are channeled into a cultural framework, within the context of ancestors. Neglect of the calling would lead to progression of the illness, whereas being an apprentice THP en route to a fully-fledged THP is believed to result in recovery. When *ukuthwasa* appears ineffective, individuals might be re-diagnosed as suffering from *ukuhlanya*, and referred to a clinic. That *ukuthwasa* is regarded a therapeutic undertaking which in some individuals might not succeed, leading to a referral to psychiatric treatment, was also observed by Schweitzer (1977). The interpretation of *ukuthwasa* as some form of treatment is partly congruent with the sparse literature on this matter, in which *ukuthwasa* has been described as a way of "reintegrating and channelling psychopathology and emotional instability" (Lamla, 1975) and a therapeutic intervention consisting of "milieu therapy (i.e., living with a THP), traditional medication, dream interpretation, ritual dancing sessions and ritual ceremonies with or without animal sacrifices" (Buhrmann, 1982). These are still the elements of *ukuthwasa* today. The exact pharmaceutical characteristics, underlying mechanisms and effects of the traditional medication that is prescribed to apprentice THPs are unclear.

Based on our findings, we speculate that *ukuthwasa* might be a kind of natural experiment whereby the cultural interpretation and handling of a mental illness

associated with the calling leads, at least in some individuals who are selected by the THPs as apprentices, to a highly functional adaptation. It transforms individuals with certain upsetting and disruptive perceptual phenomena and other symptoms into respected members of the society with a defined work, role and social status. Acquisition of a respected role in society and the possibilities for remuneration might help patients to channel their symptoms in more constructive ways.

Strengths and limitations

The strengths of the present study are that our team has multi-pronged and established recognition in the research area over a number of years, and that we were able to collaborate with local specialists. Our project manager has an in-depth understanding of both traditional healing and psychiatry, and has widespread connections with Zulu leadership, other civic leaders and a THP organization. The latter also entails limitations, in that we were identified with the leadership of the Zulu Kingdom and not necessarily with more secular civic leadership and political actors. We cannot claim to have been a neutral party, and possibly our research was seen as contributing to legitimacy of THPs and reinforcement of Zulu traditional identity and beliefs.

Other limitations include the small numbers from the various categories of participants, and that the selection of informants is mainly based on convenience of access, restricting the representativeness and generalizability of the findings. In addition, our data is mainly based on retrospective and sometimes even second-hand accounts, with the potential for biased or inaccurate memories. Although the anthropologists resided in the region multiple times and the psychiatric epidemiologists visited the study area repeatedly and attended meetings with local residents, including some participants, they did not speak isiZulu and were not from the region. As a result, more time was required to understand the culture and establish trust. Furthermore, relying on a local interpreter increased opportunity for error. However, it also had benefits, such as creating trustworthiness when collecting data.

Many people hold complex and mixed views and beliefs about mental experiences, often consulting both biomedical services and THPs simultaneously (Burns & Tomita, 2015; Green & Colucci, 2020; Labys et al., 2016). The inclusion of some participants recruited from a clinic and diagnosed with psychotic disorders could be construed as an approach from a distinctly "Western biomedical" point of view. However, the reality is that within KZN, "Western biomedical" concepts are firmly embedded, and often coexist with traditional explanatory concepts. We argue that identifying some participants from a "biomedical" setting did not negatively prejudice our aim to explore the *ukuthwasa* phenomenon and process from both an etic and emic perspective.

Conclusion

Symptoms of mental illness may be viewed as evidence of a calling to become a THP and *ukuthwasa*, the process of training to become a THP, may have mental health benefits. Despite its limitations, this study contributes to the understanding of the ancestral calling and has generated a new hypothesis regarding the apprenticeship of becoming a THP in a rural community in KZN today. That is, the process of *ukuthwasa* might be culturally sanctioned healing which, in some individuals, moderates mental disturbances that in psychiatric taxonomy seem to resemble psychotic symptoms, such that they become meaningful and positively valued features of a new role in the community as THPs. *Ukuthwasa* may function as an integrated training/intervention containing the elements of work, role, identity, community support and care considered most effective in state-of-the-art early intervention strategies for early psychosis, and seems to facilitate a surprisingly rapid recovery. This may not result in full recovery, as some of the hallucinatory experiences remain as part of the healing profession, but the process seems to be successful in the sense that individuals no longer experience distress and function in a highly esteemed and lucrative role in society. We have suggested that *ukuthwasa* may function as a culturally sanctioned process aiding recovery and integration into a meaningful social role. This research raises several other interesting research possibilities. For example, it would be interesting to explore in subsequent research whether and how the changing sociopolitical context has impacted and continues to impact the process, role and therapeutic value of *ukuthwasa*. In this article we did not address this question; rather, we described the changing sociopolitical environment as a backdrop and context for our study. We would argue that our findings have demonstrated the importance of looking at the process of *ukuthwasa* in social and political context over time, rather than seeing *ukuthwasa* as a static exoticized traditional event. Exploring then how this changing sociopolitical environment may have impacted and shaped the value of *ukuthwasa* over time, appears to us a worthwhile future avenue for research. In addition, we argue that future investigations into the process of *ukuthwasa* are needed to examine longitudinally whether and how this cultural intervention might influence the course and outcome of experiences and phenomena regarded within the psychiatric framework as features of psychosis.

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Supplemental Material

A glossary of isiZulu words will be available online as supplemental material with the article.

Notes

1. The ancestral calling mainly applies to one of the three subtypes of traditional health practitioners, namely to the *isangoma* (diviner). The other subtypes include the *inyanga* (herbalist) and *umthandazi* (faith healer), who usually have not received a calling. For the purpose of readability, we use the umbrella term "traditional health practitioners" throughout the article, with the understanding that this term is heuristic as traditions have changed and continue to change.
2. Indigenous language of the Zulu.
3. Since all the fieldwork took place within the designated trust of the Zulu Kingdom and communal area, we characterized our informants whose first language was isiZulu and who were living in the communal area, as Zulu. In other situations and regions of South Africa, such a tribal designation might not have seemed salient.
4. At the time of the study a doctoral student in medical anthropology and a psychiatrist in training.
5. An anthropologist who supervised the ethnography.
6. Our interpreter, who is the niece of the late anthropologist Harriet Ngubane, had abandoned her position as a school principal to become a THP in the new South Africa.

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