Case Formulations on Selected Mental Disorders by Clinical Psychologists and Traditional Health Practitioners: A Comparative Analysis

By

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DEDICATION

This thesis is dedicated to my late father Madimetja Isaac Makgabo. I always wish that Heaven could have waited just a little longer.

DECLARATION

I declare that **Case Formulations on Selected Mental Disorders by Clinical Psychologists and Traditional Health Practitioners: A Comparative Analysis** is my own work and all the sources I have used and quoted have been indicated and acknowledged employing complete references. This work has not been submitted before for any degree.

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Full names	Date

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ABSTRACT

With the realisation that both the traditional and western health care systems are consulted in South Africa, the Traditional Health Practitioners Act, No 22 of 2007 was promulgated. In addition to the Act, there was a growing body of literature proposing the integration of the two health systems to improve the overall South African health system. This study explored the possibility for such collaboration by investigating case formulation by western-trained clinical psychologists and traditional health practitioners regarding selected cases of mental disorders.

A qualitative research design, specifically a case study method was used in the present study. Six clinical psychologists and six traditional health practitioners were selected through purposive sampling and were requested to participate in the study. The researcher further sampled two vignettes of Major Depressive Disorder and Schizophrenia for data collection purposes. Data was collected through semi-structured interviews and vignettes and analysed through Braun and Clarke's thematic content analysis steps. Six main themes that related to case formulations by clinical psychologists emerged. These themes were: a). Collateral information as a major determinant in the assessment and treatment of mental illness; b). Classifications of mental illness; c). The symptomatology of mental illness; d). Causes of mental illness; e). The multidisciplinary approach in the treatment of mental illness; and f). Views regarding the collaboration of Clinicians and Traditional Health Practitioners. On the other hand, eight themes that related to the case formulations by traditional health practitioners were identified. These themes were: a) Divination as the main process of enquiry, b) Descriptive names of mental illnesses, c) Conceptualisations of stress-related and depressive disorders by Traditional Health Practitioners, d) Views on causes of mental illness, e) The effectiveness of the Western approach in the treatment of some forms of mental illness, f) The relationship between religion and African traditional practices; g) A calling as symbolised by symptoms of mental illness, and, h) Traditional health practitioners' views on the collaboration between themselves and western health practitioners.

The study has further revealed that there are some similarities as well as differences in the way clinical psychologists and traditional health practitioners formulate cases. The convergences in their formulations were revealed in the following themes; a). The conceptualisation of stress and related conditions; b). The western system is the most appropriate in the management of stress-related and depressive disorders and c). The benefits of the collaboration between western and African healing systems. The following divergences were further identified from the way clinical psychologists and traditional health practitioners formulate their cases: a). The conceptualisation of the presenting symptoms from the two cases; b). The causal factors of mental health conditions; c). The initial methods of enquiry; and d). The management of mental health conditions. The study has further revealed that both traditional health practitioners and clinical psychologists have positive views regarding the collaboration of western and African traditional health systems, especially in the management of mental disorders. The study has further uncovered the convergences and divergences in the conceptualisation of mental health conditions between traditional health practitioners and clinical psychologists.

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CHAPTER ONE

INTRODUCTION AND BACKGROUND

1.1 Background to the study

Mental disorders are amongst the leading causes of disability globally. Nearly thirty percent of people around the world experience some form of mental health problem (Collins & Saxena, 2016). Studies have shown the prevalence of mental disorders and their disabling effect at individual and national levels to be quite significant (Alem, Destal & Araya, 2017). A recent report by the World Health Organisation (WHO) indicates that mental disorders are a serious problem with 300 million people suffering from depression (WHO, 2017). The burden of mental disorders is a major challenge for both developed and underdeveloped nations globally. South Africa is amongst the countries experiencing a significantly higher prevalence of mental health conditions.

There exist two modes of mental health care delivery in South Africa, namely, the Western and traditional mental health care systems. The two systems exist side by side, yet remain largely functionally unrelated in any intentional sense. According to Van Rooyen, Pretorius, Tembani and Ten Ham (2015), these dualistic and dichotomised mental health systems can collaborate to produce a synergetic outcome that will maximize the delivery of mental health care services in South Africa. It is an indisputable reality that a significant proportion of the South African population, particularly the indigenous African people, make use of traditional forms of health care instead of (or in addition to) western healthcare systems (Truter, 2007). It is estimated that there were about 200 000 traditional health practitioners in South Africa in 2007 (Truter, 2007). Some of the reasons why traditional health practitioners are preferred to Western-trained mental health practitioners include their cultural perceptions of mental illnesses, their availability, accessibility, and affordability (Galabuzi, Agea, Fungo & Kamoga, 2010). Additionally, traditional health practitioners reflect the socio-religious structure of indigenous societies from which the practice is developed (Petzer & Mngqundaniso, 2008). Traditional health practice has relatively recently been mainstreamed through the promulgation of the Traditional Health Practitioners Act No

22 of 2007 in South Africa. The purpose of the Act is to a) establish the Interim Traditional Health Practitioners Council of South Africa; b) provide the registration guidelines for the registration, training and practice of traditional health practitioners; and c) serve and protect the interest of the public who utilise the services of traditional health practitioners.

Limited research has been conducted to explore the factors that support or obstruct collaboration between traditional health practitioners and Western-trained practitioners (Robertson, 2006). To develop models of collaboration that can promote a workable relationship between the two healing systems, there is a need to understand how traditional health practitioners and Western-trained health practitioners (such as clinical psychologists) assess, diagnose and treat mental health conditions.

1.2 Problem statement

The majority of people in South Africa consult both traditional and western-trained health care practitioners for a range of health problems, including mental illness. This type of mental health care delivery pluralism has existed for decades in South Africa (Meissner, 2009; Sorsdahl, Stein & Flisher, 2010). The Western biomedical health care system is government-sanctioned and supported (Campbell-Hall, Petersen, Bhana, Mjadu, Hosegood, Flisher & MHaPP Research Programme Consortium 2010; Dookie & Singh, 2012) whilst the traditional health system is unsupported and unregulated (Mbatha, Street, Ngcobo & Gqaleni, 2012; Semenya & Potgieter, 2014). Despite the lack of government support, the traditional health care system has continued to exist. One of the explanations for this is that traditional health practitioners provide culturally appropriate care which is linked to indigenous explanatory models of mental illness held by many South Africans (Mzimkulu & Simbayi, 2006; Sodi & Bojuwoye, 2011). On the other hand, the Western health care system is often perceived as a hegemonic explanatory model of illness that tends to focus mainly on physiological and psychological states (Rowson, Willott, Hughes, Maini, Martins, Miranda, Pollit, Smith, Wake & Yudkin. 2012).

While a collaborative relationship between the two systems, (that is, the traditional and western), is the most appealing future direction in the delivery of mental health care services in South Africa, there have been a few studies that investigated how such a collaborative relationship could be realised.

This study aims to explore the possibility for such a collaborative relationship by investigating case formulation by western-trained clinical psychologists and traditional mental health practitioners concerning selected cases of mental disorders.

1.3 Purpose of the study

1.3.1 Aim of the study

This study aimed to explore case formulations by Northern Sotho traditional health practitioners and clinical psychologists in respect of vignettes of mental disorders presented to them.

1.3.2 Objectives of the study

The objectives of the study were:

- To describe the conceptualisation of the causes of mental disorders by traditional health practitioners and clinical psychologists;
- To compare what traditional health practitioners and clinical psychologists consider to be the nature of the presenting mental disorder as reflected in the case vignettes;
- To examine the traditional health practitioners and clinical psychologists' understanding of the appropriate treatment that should be provided for each of the presenting problems reflected in the case vignettes; and,
- Based on their conceptualisation of the possible causes, nature and treatment, develop a model to explain convergences and divergences in the traditional

health practitioners' and clinical psychologists' case formulations for mental disorders.

1.3.3 Research questions

a. What are the conceptualisations of clinical psychologists and traditional health practitioners of the names and causes of mental disorders from the case vignettes presented to them?

b. How do traditional health practitioners and clinical psychologists understand the nature and the symptomatology of the presenting mental disorders as reflected in the case vignettes?

c. What are the methods and procedures that traditional health practitioners and clinical psychologists use to treat the mental disorders that were presented to them from the case vignettes?

1.4 Significance of the study

A study of this nature may make the following contributions:

- By looking at case conceptualisations by both traditional health practitioners and clinical psychologists, this study could broaden the understanding of the commonalities and differences in the two perspectives of the management of mental disorders. This knowledge may improve the mental health services for the end-users of such services.

- The study could also contribute to the development of cultural models of the conceptualisation and management of mental disorders by traditional health practitioners. The development of such models could help to forge closer interaction between traditional health practitioners and Western-trained mental health practitioners in South Africa and other developing countries.

- The study hopes to contribute to the body of knowledge that will help in the development of policies on the collaboration of western-based and African

cultural-based approaches on the management of mental disorders in the country.

1.5 Operational definition of concepts

- **Case formulation:** This refers to the process of creating or preparing a case carefully, giving particular attention to details, and expressing those ideas in carefully chosen, profession-specific language (Hornby, 2010). For this study, case formulation will refer to the understanding and detailed explanation of selected cases by clinical psychologists and traditional health practitioners as they are presented to them by the researcher.

- **Mental disorder:** According to Hornby (2010), this refers to anything that has to do, or is connected with, illnesses of the mind. For the present study, the concept of mental health conditions will bear the same meaning, and will specifically refer to major depression and schizophrenia. Other concepts such as mental illness, mental health problems and mental health conditions, when used in the context of the present study, will also be referring to mental health conditions.

- **Psychologist:** This refers to a person registered under the Health Professions Act (56 of 1974) as a Clinical Psychologist (Health Professions Council of South Africa, 2004). In the context of this study, the concept of clinical psychologist will carry the same meaning as the above.

- **Traditional health practitioners:** According to the Traditional Health Practitioners Act Number 22 of 2007, a traditional health practitioner (THP) is defined as any person who registers in one or more of the categories of traditional health practitioners under the Act. According to Tshehla (2015), the Act further categorises traditional health practitioners into ‘diviners, herbalists, traditional birth attendants and traditional surgeons. For this study, the concept of traditional health practitioner will carry the same meaning as the one in the Act.

1.6 Conclusion

This chapter provided the background to the study, further demonstrating the gap in the knowledge about the commonalities and differences between clinical psychologists and traditional health practitioners in the conceptualisation of mental disorders. The different studies were highlighted to show how much of a burden of mental disorders does the world, and South Africa in particular, experience. This study makes significant contributions to the body of knowledge and the development of a model of collaborations by clinical psychologists and traditional health practitioners in the management of mental disorders. The next chapter will discuss the literature on the western views of mental disorders, further building on the gaps that the present study sought to fill.

CHAPTER TWO

WESTERN VIEWS ON MENTAL HEALTH, ILLNESS AND HEALING

2.1 Introduction

The previous chapter presented the introduction to the study. This chapter aims to unpack the literature as it relates to the study. It begins by outlining the prevalence of mental illness, followed by a discussion on the types of mental illness with special attention to depression and schizophrenia as the main conditions that are at the centre of this investigation. The chapter further looks into different culture-bound symptoms as well as biological and psychological explanatory models of mental disorders. The chapter then looks into the management of mental illness as well as the background and role of psychology in mental health. It concludes by reflecting on the prevailing views regarding collaboration between western and African health systems in addressing mental health challenges.

2.2 Prevalence studies on mental illness

Mental health issues are continuing to rank at the top of the list of the main health concerns worldwide. It is ranked as a significant public health challenge, the leading cause of disability and the third leading cause of overall disease burden in the WHO European Region. It accounts for most of the deaths of people 20 years and younger living with mental illness as opposed to the general population (WHO, 2018). A report from the American Psychiatric Association has further shown that there is a high disparity in the lifespan of people with serious mental health problems as compared to the general population. This suggested that people who receive mental health treatment in public hospitals have a higher mortality rate and die about 25 years earlier than the general population (Druss, Chwastiak, Kern, Parks, Ward & Raney, 2018). In 2016, mental and affective disorders were found to have affected more than 1 billion people globally, causing 7% of the global burden of disease and 19% of the years lived with disability (Rehm & Shield, 2019). COVID-19 has added to the extent of the global burden of mental health challenges, affecting healthcare workers, non-infectious chronic

patients, COVID-19 patients and quarantined persons (Wu, Jia, Shi, Niu, Yin, Xie & Wang, 2020). Most countries continue to face difficulties in public health as people are mostly affected by the weight of mental illness.

In China, in 2019, the lifetime prevalence of psychiatric disorders was found to be 16.6% while the 12-month prevalence was 9.3% in the general population based on the findings from the two-stage sampling study (Xiang, Zhang, Wang, Zeng, & Ungvari, 2019). Mental illness was also globally highly ranked amongst nursing personnel as reported by the outcomes of the study by Pinhatti, Ribeiro, Soares, Martins and Lacerda (2018). They discovered the global prevalence rate of 32.6% of minor mental illnesses in young female married nursing workers. Malaysia has seen a significant increase in the prevalence of mental health problems as reported by The National Health and Morbidity Survey (NHMS). They have increased from 10.7% in 1996, 11.2% in 2006 and 29.2% in 2015 with higher statistics in females than in males (Salleh, 2018). In South Asia, in 2017, 8 389 out of 158 555 individuals who were investigated through 34 epidemiological studies across seven countries were found to be having mental disorders (Ranjan & Asthana, 2017). Baker (2020) suggests that there is a high prevalence of mental health problems in England as shown by a ratio of 1 in 6 adults having suffered either anxiety or depression, and 1 in 8 children have suffered at least one mental health problem.

Marital status was identified as one of the demographic determinants in the prevalence of mental illness in Zambia. The findings of the study by Nseluke and Siziya (2011) indicated that out of the sample of 206 patients who were investigated, 40% of the married participants were less likely to experience mental illness as compared to their separated and divorced counterparts. The findings of the study that was conducted by Jenkins, Njenga, Okonji, Kigamwa, Baraza, Ayuyo, Singleton, McManu and Kiima (2012) in Maseno, Kisumu District of Nyanza Province, Kenya, showed a prevalence of 10.8% of common mental disorders were found, especially in those who were older and those with poor physical health.

In 2006, the prevalence of mental illness in the Western Cape was at about 25.0% for adults and 17.0% for children and adolescents (Kleintjes, Flisher, Fick, Railoun, Lund, Molteno, & Robertson, 2006). The only available data on the prevalence of mental illness in the Western Cape was from the findings of the South African Stress and Health Survey (SASH) conducted in 2004 which suggested a high 12-month and lifetime prevalence in South Africa to be from the Western Cape (39.4%). The survey further indicated a prevalence of anxiety disorders (18.9%), mood disorders (13.7%) and substance use disorders (20.6%) in the Western Cape (Jacobs & Coetzee, 2018). Post-traumatic Stress Disorders and Childhood Behavioural Disorders are also amongst the common mental disorders that are prevalent in the Western Cape (Corrigall, Ward, Stinson, Struthers, Frantz, Lund, Flisher & Joska, 2007).

2.3 Types of mental health problems

The international classification of mental disorders and the Diagnostic and statistical manual of mental disorders among others give a synopsis of many forms of psychopathology that are grouped into mood disorders, anxiety disorders, Schizophrenia Spectrum and Other Psychotic Disorders, Trauma- and Stressor-Related Disorders and Substance-Related and Addictive Disorders among others. Many other disorders may differ in their level of prevalence from the ones listed above. For this study, the focus will be placed on both mood disorders and schizophrenia spectrum and other psychotic disorders with special emphasis on depression and schizophrenia as the two main conditions at the centre of the enquiry.

2.3.1 Depression

Depression reportedly contributes to the burden of disease in all parts of the world (Tomlinson, Grimsrud, Stein, Williams & Myer, 2009). Depressive disorders, particularly depression, can be traced back to as far as the prehistoric Greeks who referred to it as melancholia. The Greeks have also originated the term ‘mania’, which they used to refer to a particular disposition, a celestial state granted by the gods, or a reaction that may have involved either anger or excitation (DeRubeis, Strunk & Lorenzo-Luaces, 2016). Mood disorders have been estimated to be affecting 20 percent of the general

population of the United States of America, with 17 percent having a probability of depression over their lifetime while bipolar mood disorder is estimated to be affecting only 01 percent of the population (Gregory, 2019). So far, mood disorders have the highest lifetime prevalence rate and suicide risk that surpasses that of the other psychiatric disorders and are mainly characterised by the disturbance in one's mood (Lu, 2015).

Depression is further assumed to be two to three times more prevalent than other psychiatric disorders in western countries, especially in people living with HIV while there is little literature available in the case of sub-Saharan African (Bernard, Dabis & de Rekeneire, 2017).

In the case of South Africa, an estimated 9.8% of adults experience depression at some point in their lives, of which only 25% seek intervention, therefore, suggesting a huge treatment gap for mental illness, particularly depression (Cuadros, Tomita, Vandormael, Slotow, Burns & Tanser, 2019). Ajaero, Nzeadibe and Igboeli (2018) indicate that urban adolescents were more depressed than their rural counterparts with the difference further signified by race, age, income and province of residence in South Africa. The results of the study by Mudiriza and De Lannoy (2020) in South Africa further showed a 72% prevalence of depression among the youth in South Africa during the COVID-19 pandemic and the subsequent lockdown. These statistics were found to be higher than those obtained from the youth who were investigated outside the COVID-19 context. The study by Onuh, Mbah, Ajaero, Orjiakor, Igboeli and Ayogu (2021) showed some margins of 82.16% prevalence of low depression status in urban areas and 81.34% in rural areas of the nine South African provinces. The factors which contributed to these slight differences included race, level of income and the completion of secondary and tertiary education.

The symptomatology picture of depression may be perceived differently from one context to another, further determining the help-seeking behaviour. Mayston, Frissa, Tekola, Hanlon, Prince and Fekadu (2020) shows that the symptoms of depression are undetectable in patients receiving treatment from health facilities. They further show that

spiritual causal factors and biomedical treatment methods are often considered if the symptoms are highly severe. Depression was reported to be viewed differently by male students at the University of KwaZulu-Natal, suggesting that the hegemonic norms of masculinity imparted on them through the process of socialisation influenced their reaction to depression. Externalising behaviours such as substance use and sexual activities seem prominent in an attempt to deal with depression as reported by the participants (Mthethwa, 2018). As much as one has to present with five or more symptoms to meet the diagnostic criteria for depression according to the DSM-5, it is paramount for the clinician to have an individualized approach as symptom profiles may differ from each other as their association with demographic variables, personality traits, lifetime co-morbidities, and risk factors (Fried & Nesse, 2014).

The causal factors for depression have always been the subject of enquiry for many researchers and scholars alike. Bembnowska and Jośko-Ochojska (2015) have listed the factors that may serve as a breeding ground for depression to include among others long time exposure to stress and life challenges or hardships. The National Research Council (2009) and Stuart (2004) have divided the contributory factors of depression into three categories, biological factors (genetic, neurological, hormonal, immunological, and neuro-endocrinological mechanisms), environmental factors (childhood exposure to adversities and acute and stressful events) and personal vulnerabilities (cognitive, interpersonal and personality factors and traits). These factors are consistent with the findings of the study by Lawrence, Murray, Banerjee, Turner, Sangha, Byng, Bhugra, Huxley, Tylee and Macdonald (2006) with older Black Caribbean, South Asian, and White British older adults' conceptualization of depression. The management of depression both in its acute and chronic form has been found to take either the psychological, pharmacological (Hanwella, 2008) or a combination of the two approaches (Timonen & Liukkonen, 2008).

2.3.2 Schizophrenia

Schizophrenia is considered one of the most severe mental disorders further posing a heavy burden on the public health services (Mosotho, Louw & Calitz, 2011). It was

ranked amongst the first 25 leading causes of disability in 2013 with a total healthcare expenditure cost of 1,6% to 2,6% and a total of about 7% to 12% gross national product (GNP) (Chong, Teoh, Wu, Kotirum, Chiou, & Chaiyakunapruk, 2016). Africa is the second-most-populated continent, with around 1 billion people, or 15% of the world's population. In the same light, schizophrenia, which is assumed to be affecting 0,5% of the world population, has been found to affect between 4 and 5 million people in African countries (Purgato, Adams & Barbui, 2012). Though the epidemiological studies on schizophrenia have suggested a better outcome in the developing countries in the past, they have shifted from the common stance due to the social factors and determinants such as; rapid urbanization, industrialization, migration, conflict and ongoing poverty and deprivation which have changed the picture completely, especially in sub-Saharan Africa (Burns, 2012).

In the postulation made by Kyziridis (2005), the condition of schizophrenia has existed for as long as human history although the documentation of the concept of schizophrenia exists less than 100 years. Emil Kraepelin first identified this condition as a distinct mental illness in 1887, further using the word dementia praecox to define it. Eugene Bleuler then used the word Schizophrenia for the first time in 1911. Kahn, Sommer, Murray, Lindenberg, Weinberger, Cannon, O'Donovan, Correll, Kane, van Os and Insel (2015) further argues that the condition is psychotic in its presentation, characterised by a combination of such psychotic symptoms as hallucinations, delusions, disorganization, and motivational and cognitive dysfunctions. Mosotho *et al* (2011) emphasize that the similarity of schizophrenia symptoms in Sesotho-speaking individuals do not differ much from the general population although the content of the main psychological symptoms such as delusions and hallucinations is a determinant of cultural variables. The disability that is secondary to schizophrenia is positively associated with its early onset as well as its chronic course and often results from negative symptoms such as loss or deficits and cognitive symptoms inclusive of impairment in attention, working memory and executive functions. In contrast, relapse may be secondary to positive symptoms that are inclusive of but not limited to suspiciousness, hallucinations and delusions (Patel, Cherian, Gohil & Atkinson, 2014). The abnormalities in patients with schizophrenia are deemed to result in impairment in

occupational and academic functioning, parenting, self-care, independent living, interpersonal relations and leisure (U Khan, Martin-Montañez, & Chris Muly, 2013).

According to Newman and Jegg (2017) amongst the factors that are responsible for the causality of schizophrenia are genetic factors, chemical imbalances in the brain, family relationships, substances abuse and environmental factors in the form of traumatic and stressful events and exposure to viral infections. Cardoso and Silva (2018) concurs with the genetic, hereditary and environmental causality of schizophrenia, although the exact nature of the type of genetic transmission is unclear. Stilo, Forti and Murray (2011) emphasize the importance of positive family history although, at the time, no single gene of large effect has been constantly associated with the condition. However, biological factors include advanced paternal age, exposure to obstetric events and the abuse of stimulants and cannabis while social factors may include migration, urban living, and victimization as high ranked risk factors.

Rasool, Zafar, Ali and Erum (2018) suggest that people with schizophrenia are less inclined to aggression if they are on treatment. They further suggest that people with schizophrenia may benefit from the two main treatments; antipsychotic treatment and psychosocial treatment in terms of social support, treatment adherence and relapse prevention. McDonagh, Dana, Selph, Devine, Cantor, Bougatsos, Blazina, Grusing, Fu, Kopelovich and Monroe-DeVita (2017) indicate that the older pharmacological drugs with more superior outcomes included clozapine, olanzapine, and risperidone, which were similar to haloperidol, with beneficial outcomes but with less adverse event outcomes. Psychosocial interventions on the other hand improved functional outcomes, the quality of life and main illness symptoms and enhance relapse prevention. There is an apparent overlap between schizophrenia and some culture-specific conditions as suggested by aberrant behaviours and psychological phenomena (Niehaus, Oosthuizen, Lochner, Emsley, Jordaan, Mbanga, & Stein, 2004). Dein (2017) asserts that the condition is deemed similar across different cultures and societies with the difference arising only from the content of symptoms and not in the underlying causation and structure. These arguments have given rise to the pursuit of different cultural conceptualisations and connotations of mental disorders and their similarities and

differences, and the inclusion of culture-bound syndromes in the international diagnostic guidelines.

2.4 Culture-bound syndromes

Culture remains a concept for which meaning has been sought throughout the history of human existence. It has always remained an area of interest due to the impact it has on humans and their day-to-day activities. Aina and Morakinyo (2011) believe that culture profoundly affects human cognition, feelings, self-concept and the diagnostic processes as well as treatment decisions. Thus, culture is best defined as “a totality composed of a complex system of symbols possessing subjective dimensions such as values, feelings and ideals and objective dimensions including beliefs, traditions and behavioural prescriptions articulated into laws and practice” (Aina & Morakinyo, 2011).

A significant body of research has attempted to document the role of culture on mental illness, further looking at the impact it has, not only on the experiences and symptomatology but also on the organisation and clustering of symptoms (Lopez & Ho, 2013). Such developments have given rise to the development of a subcategory of ‘culture-bound syndromes’ (CBS), as first developed by Yap (1969) which is further recognised by the *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR),* an international classification of disorders. CBS are better described as any of some recurring, area-specific patterns of abnormal behaviours that fall outside the prescripts of the western psychiatric diagnostic classifications, further considered to be illnesses within different indigenous localities, bearing probable area-specific names (Niehaus, Oosthuizen, Lochner, Emsley, Jordaan, Mbanga, Keyter, Laurent, Deleuze & Stein, 2004).

The DSM-IV is the first diagnostic manual that documented the culture-bound syndromes located in the appendices. The DSM-IV-TR further improved on the previous version to include and define the CBS as: “recurrent, locality-specific patterns of aberrant behaviour and troubling experiences that may or may not be linked to a particular DSM-IV diagnostic category” (Karthick & Barwa, 2017; APA, 2000). The emergence of the DSM-V has brought a name change to the previously-termed CBS to

the ‘cultural concepts of distress’, further defining them as “ways that cultural groups experience, understand and communicate suffering, behavioural problems or troubling thoughts and emotions” (Karthick & Barwa, 2017; APA, 2013). The difference in the connotations and meanings that are attached to specific mental conditions may be secondary to the theory that governs such cultural conceptualisations of illness. Many different theories have attempted to explain different mental health problems, causes and treatment approach.

2.5 The explanatory models of mental health problems

A human being, complex as it may be, has been a subject of investigation throughout the existence of humankind. The ongoing process of investigation has always referred to various sources that may be in the form of social and cultural norms and practices and yardsticks as well as scientific investigations. The outcome of such processes has given birth to the explanatory models that attempt to document and outline the findings in a more palatable and meaningful way. As it is one of the objectives of this paper, to understand mental health problems as a subject matter, the researcher refers to the biogenic and psychogenic explanatory models to understand human behaviour and the mental health problems thereof. The researcher begins by outlining the biological model of human behaviour.

2.5.1 The biological explanatory models

The biological models, through their main assumption that human beings are biological beings, always attempt to understand humans by referring to the biological processes in their brains. Proponents of the biological model purport that human thoughts and feelings are a result of biochemical and bioelectrical processes through their brain and body. Abnormal behaviour from this perspective is viewed as a malfunction of certain parts in an organism, most probably as a result of problems in the brain anatomy or chemistry (Comer, 2013). With the human brain being divided into the central nervous system, autonomic nervous system and the endocrine system, Butcher *et al* (2013) views mental disorders as disorders of either of the three that may be a result of

inheritance or some pathological processes which occurs in isolation or conjunction with the other psychological and sociocultural causal factors.

Although some forms of abnormal behaviours may be a result of structural damage to the brain cortex, others may be secondary to the chemical processes that occur in the brain. Butcher *et al* (2013) distinguish the biological causal factors of abnormal behaviour in four categories, namely the neurotransmitter and hormonal abnormalities, genetic predispositions, temperament, brain dysfunction and neural plasticity. Biological factors are deemed pivotal in the aetiology of schizophrenia, major depressive disorder, attention-deficit/hyperactivity disorder and substance-related disorder as mainly biologically brain-based health problems, and the treatment initiative mainly aims at restoring the brain's chemical balance to alleviate the symptoms (Deacon, 2013).

2.5.2 The psychological explanatory models

Mental health, as one of the global challenges, is understood with regard to different contextual orientations of different societies and groupings. It is further a subject of a particular social or individual theoretical school of thought. The western view of mental health problems has commonly been influenced by the biogenic and psychogenic approaches. According to Comer (2013), as opposed to the biogenic approach that posits that mental health problems emanate from biological factors, the psychogenic approach views these ill conditions as a result of psychological factors, such as unconscious psychological processes, relational problems with the world and others, and developmental challenges. Many theorists have attempted to formulate on and explain mental health problems from these different dimensions as informed and guided by their schools of thought and their personal experiences, as indicated below:

2.5.2.1 The psychodynamic model

As it is commonly said, the psychodynamic approach is viewed as the oldest and most famous approach that researchers, scholars and practitioners have always consulted with to understand human behaviour and abnormal behaviour in particular. This model was first formulated by the Viennese neurologist, Sigmund Freud (1856–1939) as a

result of his discoveries during the time he worked with the physician, Josef Breuer (1842–1925), conducting experiments on hypnosis and hysteric conditions with no apparent medical cause (Comer, 2013).

Freud intended to develop a more comprehensive theory of psychopathology that based its emphasis on the inner dynamics of the unconscious motives commonly known as psychodynamics that remains at the heart of the psychoanalytic approach. Freud's methods of assessment and treatment can be referred to as psychoanalysis (Butcher, Mineka & Hooley, 2013). Freud was of the view that mental illness emanates from the unconscious and unresolved internal conflicts of a person's mind (Freud, 1924; 1933). He further postulated that such unresolved conflicts begin in early childhood eventually resulting in mental health problems through their interruption of the development of the id, ego and superego that constitute the human psyche (Corey, 2009; Corsini & Wedding, 2008). Unlike the biogenic approaches that view symptoms as a clue suggestive of a disorder, Freud believed that a symptom is an indication of an expression of an inner conflict (Corsini & Wedding, 2011). Towards the end of the 20th century, the psychodynamic approach has been deemed useful in the treatment of mental illness in conjunction with other modes of treatment, especially with schizophrenia as indicated by Mueser and Berenbaum (1990). About a decade into the 21st century, Josias supported the argument by emphasizing the effectiveness of the psychodynamic approach as applied parallel with the biological, social and pharmacological modes of treatment of schizophrenia as opposed to its application in isolation (Josias, 2009). For Freud and his followers, schizophrenia as the focal point of this study is understood to result from severe distortion of psychological functioning (Glassman & Hadad, 2009)

2.5.2.2 The behavioural model

After the development of the psychodynamic model, many theories began to emerge with the idea of supporting or opposing the contentions made by the former approach. The fifth and sixth decades of the 20th century gave way to the emergence of the behavioural approach which sparked as a systematic approach to the assessment and

treatment of psychological disorders. The key figures that played a profound role in the development of these theories include Ivan Pavlov, B.F. Skinner and John B. Watson among others (Schiffner, Fuhrmann, Reimann, & Wiltschko, 2018).

The main hypotheses that the proponents of this theory hold are that behaviour is a function of its consequences in the form of reinforcement versus punishment and that the brunt of the environmental factors is dependent on the cognitive processes of how these external stimuli are perceived (Corsini & Wedding, 2011). Therefore, learning is influenced by physical variables such as material or environmental reinforcement (Reimann, 2018).

Characteristics of this model are the concepts of operant conditioning, modelling and classical conditioning. Operant conditioning is defined as the process of learning in which rewarding behaviour is likely to be repeated (Comer, 2013). Modelling is defined as a process of learning in which individuals respond to behaviours that are imitated from others, and classical conditioning is a learning process in which two separate events that are produced closer to one another in time yields the same response (Comer, 2013; Corey, 2009).

Behaviourists posit that human behaviour, including the manifestations of mental health problems, is learnt from the external environment (Butcher, Mineka & Hooley, 2007). These scholars may perceive the same condition as a result of faulty learning where faulty thinking and stimulation of symptoms is rewarded by attention (Saddock & Saddock, 2007). Pathology, in their view, emanates from the learning of maladaptive behaviour, where intervention is tailored towards helping patients to realize and replace those maladaptive habits with more appropriate ones (Bernstein, Penner, Clarke-Stewart and Roy, 2012; Comer, 2013) through the application of the principles of modelling, classical conditioning and operant conditioning (Wilson, 2011).

2.5.2.3 The humanistic-existential model

Other theorists who further attempted to understand human nature, behaviour and pathology are the humanistic-existential scholars. They developed this approach in the

1940s to complement their predecessors; the behavioural and psychoanalytic approaches. The development of this approach was influenced by the works of a few key theorists that included; Abraham Maslow, Carl Rogers and Rollo May (Vachon, Bessette & Goyette, 2016). Unlike their predecessors who have focused more on an individual at an objective level, the proponents of this approach, as influenced by existential and phenomenological philosophies, have always referred to the subjective experience and human agency as their vantage point (Schneider, Fraser Pierson, & Bugental, 2015; Watson & Schneider, 2016). Contrary to most scholars who have always referred to both concepts synonymously, Butcher, Mineka and Hooley (2007) separate the two by referring to the former as an approach that focuses itself on the present conscious processes, further placing attention on people's inherent capacity for responsible self-direction while the latter concerns itself about the irrational tendencies and the difficulties inherent in self-fulfilment. The main concepts that hold the centre in this approach are; free will, self-efficacy and self-direction (Cherry, 2019).

Though the founders of this approach deviated from the common practice of their predecessors, of looking at pathology as explained by their theories, the humanists and existentialists placed their focus on striving to help people fulfil their potential and maximise their wellbeing (Cherry, 2019). In their view of pathology, they argue that mental health problems mainly develop when circumstances in a person's environment block the natural personal drive towards self-actualisation (Sartre, 1956). According to Butcher *et al 2007),* the humanistic approach views pathology as one's tendency to block or distort personal growth and the natural tendency towards physical and mental health while existentialists view pathology as emanating from one's inability to deal constructively with existential despair and frustration as caused by one's failure to establish values and acquire spiritual maturity that accompanies one's freedom and existential dignity. In the view of the humanistic/existential theorists, behaviours that are labelled as 'schizophrenia' represent the individual's response to the world, which seem to be distorted as compared to others.

2.5.2.4 The cognitive-behavioural model

The last decades of the 20th century have seen the emergence and rise of the cognitive theory of Aaron T. Beck as a deviation from the common psychoanalytic approach. His idea was propelled by much criticism of the psychoanalytic hypothesis that focused more on the unconscious human processes towards an approach that acknowledged the innate cognitive processes (Rosner, 2012). From that point onwards, more theorists emerged, as they identified themselves with Beck's ideology and approach to psychotherapy. The emerging theories were then often referred to as cognitive therapies or cognitive behavioural therapies synonymously, though acknowledging the fact that they were both describing therapies that were based on the cognitive model (Knapp & Beck, 2008).

Unlike the proponents of the previously-discussed behavioural model who views behaviour as resulting from the processes of learning from one's immediate environment, the proponents of this model associates behaviour as a consequence of one's perception of their environment. The common assumption across the cognitive behavioural theories is that thinking or cognition affects behaviour, such that a change in the way of thinking may result in the alteration of behaviour and mood (Keegan & Holas, 2009). Simply put, this theory focuses on the way individuals perceive, interpret and assign meaning to events (Corsini & Wedding, 2011).

Beck first introduced the concept of schema which he defined as "relatively stable cognitive structures which channel thought processes, irrespective of whether or not these are stimulated by the immediate environmental situation'' (Beck, 1964; Rosner, 2012). From the formation of these schemas and the reaction they trigger, Beck and the other proponents of this approach did not exclude maladaptive schema-formations and pathology. In the words of Comer (2013), cognitive-behavioural theorists and therapists attribute pathology to the formation of unfounded and maladaptive assumptions from which we develop disturbing and inaccurate attitudes as well as illogical thinking patterns. From Aaron T. Beck's cognitive therapy emerged more therapists such as Albert Ellis's Rational Emotive Behaviour Therapy, Donald Meichenbaum's Cognitive

Behaviour Modification and many others. All of these approaches are interventions intending to help patients realise and challenge their maladaptive perceptions and replace them with more rational and adaptive ones (Corey, 2013; Corsini & Wedding, 2011).

2.5.2.5 The modern / postmodern model

In addition to the pre-existing theories that have attempted to outline the factors and dynamics involved in psychopathology, the development and the replacement of the industrial culture with contemporary culture have given rise to the postmodern approach. The postmodern culture, in the words of Cianconi, Tarricone, Ventriglio, De Rosa, Fiorillo, Saito, and Bhugra (2015) is seen as a phase in which the level of development has characterised societies through high-level technology at the global community level, the mechanisation of reproduction of goods and the beginnings of information theory. This shift from modernity to post-modernity may also be ascertained by the change in the structure of society which impacts directly on family relations, employment, marital status and mental health/illness (Bessa, Brown & Hicks, 2013).

Some theories have suggested that mental health problems are a result of social, economic, and cultural causal factors (Aschenbrenner & Hellwig, 2009). In this case, mental illness is considered to be a result of external factors such as poverty and unemployment. In the same light, phenomena like the shift in world populations from rural areas to cities are likely to result in problems such as overcrowding, noise, pollution, urban decay and social isolation, which may result in mental health problems. Other factors like the abandonment of the indigenous ways of life and social disasters like warfare, genocide and violence have also been found to lead to a higher risk of mental health problems, especially depression, anxiety, and post-traumatic stress disorder (Aschenbrenner & Hollwig, 2009). Psychopathology may further be accounted for by the emergence of new stressors at an individual or group level or to the changing realities which are made possible by the susceptibility of their living or working environments or conditions due to their fragility, inhospitability, or the lack of emotional resources (Cianconi *et al,* 2015). The approach to the management of mental health

problems is informed by theory and the aetiological formulation of its causes as it makes sense to the intervening health professional.

2.6 The management of mental health problems

The management of mental illness has always reportedly taken the form of a combination of pharmacology and psychosocial interventions Risal, (2011) or either of them separately. The 2014 Adult Psychiatric Morbidity Survey (APMS) found that one in eight adults (12.1%) confirmed receipt of mental health treatment with 10.4% on medication while 3% were on psychotherapy. The statistical overlap is due to the 1.3% who received both treatments concurrently (Mental Health Foundation, 2016). There are also those with a positive history of active mental illness who are not on any treatment. This was supported by the findings of the study conducted by Kohn, Ali, Puac-Polanco, Figueroa, López-Soto, Morgan, Saldivia, and Vicente (2018) which was aimed at understanding the mental health treatment gap in the Region of the Americas by examining the prevalence of mental health disorders, use of mental health services, and the global burden of disease. The results of the study further depicted a high prevalence of mental illness and a global burden of disease.

Lewin (2017) clarifies the purpose of antipsychotic drugs such as phenothiazines (e.g., thioridazine), butyrophenones (haloperidol), olanzapine, quetiapine, and aripiprazole which are aimed at inhibiting the dopamine D_2 receptors. On the other hand, antidepressants lower the uptake of serotonin, norepinephrine or both and may include tricyclic antidepressants, second-generation drugs, selective serotonin reuptake inhibitors, serotonin-norepinephrine reuptake inhibitors (SNRIs) and monoamine oxidase inhibitors. Norquist and Hyman (1999) further concur by asserting that patients with depression have shown some improvements when placed on selective serotonin reuptake inhibitors (SSRIs) such as Fluoxetine and sertraline while patients with schizophrenia responded well on Clozapine though there were severe side effects associated with it.

In the assertion made by Norquist and Hyman (1999), some studies have applauded the efficacy of psychotherapeutic interventions, particularly cognitive behavioural

therapy in patients with anxiety and depression and exposure therapies with trauma patients. A study conducted by Mueser, Drake, Sigmon and Brunette (2005) further suggested that a variety of different psychotherapeutic treatment approaches like psycho-education, motivational enhancement and cognitive behavioural counselling were effective in substance abuse outcomes when dealing with a co-morbidity of a mental disorder and substance use disorders, especially when applied in combination rather than separately. De Jong (2011) further promotes the combination of social support, cognitive behavioural techniques and pharmacotherapy, especially in the management of acute mental health problems where the aim would be limited to the reduction of symptoms, provision of protection towards the patients or their immediate environment and to restore control either by the patient or their immediate support network.

2.7 The role of psychology in mental health

Psychology is one of the disciplines that are deemed to have a long past but a short history. In the words of Benjamin Jr, DeLeon, Freedheim and VandenBos (2003), the practice of psychology existed long before its recognition as a science as humans have always attempted to understand and help others with mental and emotional challenges throughout history. The evidence available traces psychology as far back as the 5th century BCE during the era of the Greek philosophers such as Socrates, Plato, Aristotle, and others who were faced with many of the same issues that are at the centre of modern scientific psychology today (Schultz & Schultz, 2015).

Other contributors like Rene Decartes (1596-1650) and John Locke (1632-1704) emerged later. Decartes believed that though the mind and the body were separated, they somehow communicated while Locke believed in the blankness of the mind as a tabula rasa at birth, awaiting experience to write on it (Kumar, 2020, slide 5-6; Downing, 2015). Mid-nineteenth century, scholars like Francis Galton and Herbert Spencer began collecting statistics on individual abilities for the beginning of the construction of scientific theories. A few years later, William James, an American philosopher, began with the advocacy of the recognition of psychology as a science (Bunn, 2017).

In 1879 Wilhelm Wundt (1832-1920), referred to as the father of psychology established the first experimental psychology laboratory at the University of Leipzig, where he could further his investigations into the psychological factors that are involved in memory and sensation. He has contributed directly to influencing the contemporary studies of abnormal behaviour (Butcher *et al,* 2007). Lightner Witmer (1867-1956) later established the first American Psychological clinic at the University of Pennsylvania, with the clinic focusing on mentally deficient children. He was later considered to be the founder of clinical psychology, which is one of the major current psychology disciplines (Butcher *et al,* 2007). Over the years, the focus of psychology has shifted from pure philosophy that made inferences from observation and logic to the utilization of scientific methodologies to study and draw conclusions about human thought and behaviour (Cherry, 2019). Today, psychology has spread into different disciplines, at the core is neuro-psychology, cognitive psychology, social psychology, and developmental psychology while at the periphery are cultural or cross-cultural psychology, community psychology, theoretical/philosophical psychology, and critical psychology among others (Brock, 2009).

Wittchen, Haertling and Hoyer (2015) argue that based on research developments, the profession, and clinical psychology, in particular, has derived a wide range of interventions for behavioural therapy, prevention, treatment and rehabilitation of mental disorders that are deemed effective. In practical terms, psychologists offer assessments, diagnoses and treatments of psychological problems and behavioural dysfunctions that may result from or be related to physical or mental health (Wahass, 2005).

In other settings, the role of the psychologist, especially in rural settings, may go beyond what is expected of them as clinicians to include advocacy roles, to provide awareness programmes, and psycho-educational services at individual, family or community levels (Jameson & Blank, 2007). Health psychologists on the other hand are active in areas that provide advisory assistance, relief, preparatory preventive care, and further promote individual and societal healthy living and prevent behaviours that may affect the individual or society's health negatively (Sinaj & Dibra, 2015).

2.8 Conclusion

The chapter aimed to discuss the views of other scholars as it relates to the prevalence rates of mental illness at the national, international and global levels. The chapter further discussed the types of mental illness with particular attention on depression and schizophrenia as well as culture-bound syndromes. The different explanatory models of mental illness were discussed, followed by the management of mental illness. The chapter progressed by including the background and role of psychology as a mental health care profession. Mental health issues remain highly prevalent, and amongst the highly ranked burden of disease, across many parts of the world. The picture of mental illness remains similar globally, only differentiated by social and cultural principles. The next chapter will discuss mental health issues within the African context.

CHAPTER THREE

THE AFRICAN PERSPECTIVE ON HEALTH, ILLNESS AND HEALING

3.1 Introduction

The construct that underpins social sciences is the indisputable reality that suggests that all social constructs and phenomena are understood regarding the social lens through which one is looking. The views of such phenomena may thus differ from one society to another, from one cultural orientation to another, and from one individual to another. Such an epitome gave birth to the African theories of African religion, social practices, health and illness among others. It is therefore imperative to look into the African worldview on matters of health and illness.

This chapter aims to discuss mental health issues with a special focus on the African continent. It begins by outlining the African views on health and illness with special attention to mental disorders. The views on causal factors are further explained, paving a way into the types of mental health problems and the culture-bound syndromes specific to the people of African descent. The treatment procedures of mental disorders are further explained. The chapter concludes by giving a glimpse into the types of traditional health practitioners and the modes of treatment relevant to the people of African descent that are found in South Africa, as well as the training and initiation process they undergo towards practising their trade.

3.2 The african worldview on health and illness

In most African communities, culture remains the cornerstone that informs people's understanding of wellbeing and illness. It is of significant importance to indicate that all societies refer to a wealth of knowledge that constitutes certain customs, values, beliefs, techniques and specialities that are amongst others, aimed at ensuring wellbeing through diagnosing, preventing and curing illness of all forms (Benedict, 2014). The constructions of the meaning of illness and health as well as the nature, cause and type of illness are social and cultural constructs and may vary in time and space, from culture to culture, and from person to person (Davison, Frankel, & Smith, 1992; Nkosi, 2012).

The centre-pole of the African culture is the strongest belief that Africans hold about the role of supernatural powers in their day-to-day affairs. For an African, wellbeing stretches far beyond a healthy functioning and lifestyle to incorporate the involvement of spiritual factors. Kpanake (2018) emphasises the relational-oriented view of self and personhood in many African cultures, which informs an individual's view of self-regarding the connection of the three distinctive agencies, namely (a) the spiritual agency that includes God, the ancestors and the other possessive spirits; (b) the social agency, including the family, the clan, and the community, with extension to humanity; and (c) the self-agency, which is responsible for the person's inner experience.

The available wealth of knowledge suggests that the strong relationship between the supernatural authorities, the living and the dead is essential in the day to day living of people of African descent. In the words of Omonzejeje (2008), the African unitary way of reality entrusts good health in the mental, physical, emotional and spiritual wellbeing of an individual, his immediate members and the community at large. The determination of good health from the Afrocentric worldview is to acknowledge the ancestral role in the maintenance of the good health of humankind, further suggesting that a good relationship with God and healthy ancestors play a pivotal role in one's good health (White, 2015; Mokgobi, 2014). The ancestors bear different names depending on one's tribal origin, with the Bapedi, Batswana, and Basotho referring to them as 'badimo' while the Amazulu and the Amaxhosa call them 'amadlozi' and 'iinyanga' respectively (Mokgobi, 2014). Good health may also be a result of good behaviour as suggested by the preservation of the values and norms of the traditions of society (Iroegbu 2005).

3.3 African view on the aetiology of illness

In the context of the African continent, illness may not always be attributable to causes of nature as stipulated by the western theories of illness causation, but also by the factors that may arise from the nature of the interrelationship between the individual, the environment and the spirits. The choice of treatment in the event of illness is informed by the causes that are attributable to that illness (Asare & Danquah, 2017). Apart from many factors that may contribute to one's ill-health, a typical African remains

superstitious in that they do not believe in coincidence, but rather, finds reason in every unexpected situation Ajima and Ubana (2018). In many African communities, ill-health may be attributable to many factors that range from: attacks from evil or bad spirits, disconnection and the ill-treatment of ancestors, spell-casting and witchcraft to the disobeying of taboos (White, 2015). Neba (2011) further categorises these causal factors into four categories which are natural causes equitable to the acts of God; moral or ritual infringement such as sexual abuse, stealing, killing or the ignorance of taboos; witchcraft or sorcery; and the involvement of ancestral spirit. Though he concurs with the two latter authors in his understanding of the causes of illness, Jegede (2005) further adds to the causes of illness, particularly mental illness, as resulting from natural causes in the form of accidents or drug use and also inheritable causes in the view of the Yoruba community of Nigeria.

In most African countries, healing systems for mental health conditions are pluralistic and encompass indigenous, religious and allopathic theories and practices (Teuton, Bentall & Dowrick, 2007). Traditional health practitioners often perceive spiritual forces to be the main cause of ill health and misfortune (White, 2015). Consequently, mental health problems are usually seen as a result of ancestral influences, bewitchment or witchcraft (Ngobe, 2015). For example, a study by Sorsdahl, Flisher, Wilson and Stein (2010) focusing on traditional health practitioners' explanatory models and treatment practices for psychotic and non-psychotic mental health problems in Mpumalanga Province, found that psychotic conditions were the only types recognised to be mental health problems, while non-psychotic conditions were not understood as mental health problems. In addition to the use of herbs and substances of traditional sources, modern ingredients were also included into their treatment practices. In her study focusing on traditional health practitioners in Mpumalanga Province, Ngobe (2015) found that mental health problems may also result from individuals disregarding ancestors and cultural customs, ignorance of the call by ancestors to become a traditional health practitioner, as well as the improper usage of traditional medicines. Whilst the above studies and a few others have tended to explain mental health problems in spiritual terms, there are few clearly articulated explanatory models for mental health problems by traditional health practitioners.

3.4 Mental health problems

According to Mufamadi (2001), the management of mental health problems in African communities in South Africa is not through any single method of treatment. Instead, he argues that the management of mental health problems may take two forms. These are either through the use of herbal medications or psychological or ritualistic interventions. Traditional health practitioners offer various forms of treatment that make use of a range of items and procedures such as the use of herbs, psychotherapy, surgical therapy and spiritual therapy (Ndetei, Mbwayo, Mutiso, Khasakhala & Chege, 2013).

Though the symptomatology and presentation of illnesses may be more similar across different cultures, the concepts that are used on the differing types of illnesses may be culturally specific. Audet, Ngobeni, Graves and Wagner (2017) outlined the Xitsonga names that are used to refer to seizure disorders (Mavabyi ya ku wa), losing touch with reality (Nhlanyi) and paralysis on one side of the body (Ku Oma Rihlanguti). A study by Ventevogel, Jordans, Reis and de Jong (2013) further outlined the types of illnesses in Burundi, South Sudan and the Democratic Republic of Congo that among others include; "*moul"* characterised by aggression, walking naked eating faeces and collecting rubbish; *"Wehie arenjo*" ('destroyed mind') or "*wehie arir*" ('disturbed mind') characterised by sadness, suicidality, talking and laughing to self; and "*Yeyeesi*" ('many thoughts') characterised by isolation, poor appetite, sadness, tearfulness, sleep problems and suicidality.

The methods applied as well as the items used in the process of management are dependent on the type and the speciality of the healer. Literature suggests some healers which may include; herbalists, diviners, prophets or faith healers, traditional surgeons as well as birth attendants.

3.5 Traditional African approaches to healing

The approach to any form of health management for African descent is influenced by the loyalty of Africans to their practices and ways of life. The treatment of various forms

of illness has been carried out through African traditional medicine. The concept of African traditional medicine and healing, or alternative medicine has been delineated as:

> The sum total of all knowledge and practices, whether explicable or not, used in diagnosing, preventing or eliminating a physical, mental or social disequilibrium and which rely exclusively on past experience and observation handed down from generation to generation, verbally or in writing and health practices, approaches, knowledge, and beliefs incorporating plant, animal and mineral-based medicines, spiritual therapies, manual techniques and exercise, applied singular or in combination, to treat, diagnose and prevent illnesses or maintain well-being (WHO, 1976, p. 8).

This concept is termed traditional due to its preservation of knowledge, practical experiences and observations that have been passed down from generation to generation in either a verbal or written form from African descent (Ajima and Ubana, 2018). African traditional medicine encompasses the mixture of physical, mystic and social elements of society, putting at its centre, the dependence on, and reference to the socio-cultural and religious indigenous knowledge systems of its custodians (Adu-Gyamfi & Anderson, 2019).

Parallel to the practitioners who treat ill-health referring to the western perspectives, some practitioners provide healing from an Afrocentric and traditional perspective, with variation from one culture to another. These practitioners are usually termed *'traditional healers'* though the Traditional Health Practitioners Act refers to them as traditional health practitioners. Mokgobi (2014) argues that the term "traditional healer" is generally used as an umbrella term but yet it encompasses varying types of healers with different types of training and proficiency, ranging from diviners (*'ngaka ya ditaola'*), sanusi (*'sedupe'*), traditional surgeons and traditional birth attendants (*'babelegisi'*) in the South African Bapedi tribe. With the situation in Ghana, the treatment pathways for mental health cases follow the path of charismatic and orthodox religious approaches followed by shrine consultations and traditional herbal treatment, sometimes the latter being used in combination (Osei, 2004; Danquah, 1982), therapeutic dieting, hydrotherapy

and divination (Akinnawo & Akpunne, 2018). Ajima and Ubana (2018) further add to the categories, traditional psychiatrists as traditional health practitioners who practice African traditional medicine to treat mental disorders through the use of shackles for restraining, canes for beating and other herbal hypnotics and sedative herbs.

It can be argued that items of medicinal effect and ritualistic procedures are equally appreciated by Africans in the restoration of good health. For the Kenyan inhabitants, the management of illness, or psychosis to be precise, has taken the form of psychotherapy of the traditional African type, surgical processes such as craniotomy; spiritual therapy which aims to restore peace between the living world and the spiritual world; and lastly, the use of herbs such as 'Rauwolfia' which is presumably rich in reserpine good for the management of mental illness (Mbwayo, Ndedei, Mutiso & Khasakhala 2013).

Traditional African medicine encompasses the use of natural healing agencies such as leaves, roots, herbs; and the application of ritual or spiritual influences (Ajima and Ubana, 2018). Although the herbs and shrubs still constitute the majority parts of plants they use, in the study that was conducted by Wubetu, Sintayehu, and Aeta (2018) in Ethiopia, it was discovered that in many instances of the treatment of mental illnesses, more preference is vested in the root part of the plant, with inhalation methods still topping the list of the preferred administration procedures. Literature suggests that the use of African traditional medicine may be applied either for good or bad intentions, though for this study, the focus will be on its application with good intentions and outcomes. The employ of traditional medicinal plants as a component of the traditional African healthcare system is still prevalent, making herbalists, in most of the African communities, to be regarded as a category of practitioners that are easily accessible and cost-effective (Mahomoodally, 2013).

Africans have approached healing differently as directed by their cultural views and norms. However, some of the methods which were found to be common among many African societies include divination, herbalism, spiritualism and trephination which will be discussed below.

African traditional medicine is a holistic health system approach that can be divided into three forms: divination, spiritualism and herbalism which will be further discussed below. Trephination will also be discussed due to its significance and people's level of reliance on it for the historical management of mental illness.

3.5.1 Divination

Another method of healing that has always been practised by many African cultures is divination. Divination entails the differing forms of communication between humans and the supernatural forces to acquire normally unattainable knowledge. Divination can either be intuitive to involve the direct reception of information, or inductive to involve the observation of signs from which meaning is derived (University of Chicago, Oriental Institute, 2010). The process of divination, which Yalsovac (2005) refers to as the desire to seek answers in one's ability to utilise a variety of tools and techniques to predict the future, dates back many centuries. The process has been used by many societies that range from ancient Egyptians, Chinese, and Babylonians to the Sumerians. Divination is the utilisation of a set of procedures that involves the ability of using a ceremony or ritual to gather information from the supernatural world that enables one to envisage the future (Azongo & Yidana, 2015). It is understood that many people, with many different diseases, may benefit from the consultation of diviners before any intervention can be sought, particularly if the aetiological factors of that particular disease is embedded in the worldview of the people of that locality (Azongo & Yidana, 2015).

3.5.2 Herbalism

In addition to divination which has been discussed before, herbalism is another speciality area that has been employed to deal with many forms of ailments in the African traditional health system. As often used interchangeably with African traditional medicine, herbal medicine is one of the oldest and most widely used health systems worldwide. This system constitutes to a larger extent the consumption of remedies with different cultures using different herbs, that are within their geographical zone, in different forms for the treatment of many common illnesses (Sekhar, Aneesh, Varghese, Vasudaven & Revikumar, 2008). Adewunmi and Ojewole (2006) argue that the

utilization of plants for medicinal purposes in Africa stretches far back, spanning many centuries. Many African plants which have always been used for medicinal purposes are assumed to be safe even though the toxicity of many other plants may not be overlooked.

In herbalism, illness is perceived at a natural and supernatural causality where treatment focuses on the physical and spiritual domains through the application of divination, incantations, animal sacrifice, exorcism, and herbs among others (Ozioma, & Chinwe, 2019). Herbalists believe that every disorder has a plant or animal product that can defuse it, referring to parts of plants such as leaves, roots, seeds and barks. These parts may be used in isolation or combination with mud, heap earth and other animal parts in concoctions, emulsions, ointments and powders (Okpalaenwe, & Odigwe, 2018). This method has stood the test of time due to society's dependence on it in the management of many forms of illness, even in present times.

3.5.3 Spiritualism

Africans has always historically held the ingrained belief that spirits control everything, including health and illness. Long before the introduction of modern health systems, Africans have always referred to spirituality for a cure (Edwards, Makunga, Thwala & Nzima, 2006). The spiritual aspect of humans is deemed as a critical component of completeness, such that a complete person is the one characterised by the balance between the physical, psychological and spiritual components (Okpalaenwe & Odigwe, 2018). Spirituality is defined by Verghese (2008) as a globally acknowledged concept that involves obedience and belief in an all-powerful force referred to as God who controls the creation. The role of spirituality in mental health was discussed by, Chingarande, Jack, Ward and Taylor (2016) as it was found that the participants in their study attributed mental illness to ancestral spirits and possession by an evil or aggrieved spirit. The idea behind spiritual care or spiritual healing encompasses giving attention to the whole person in respect of their physical, emotional, social and spiritual components (Mthembu, Wegner & Roman, 2018).

3.5.4 Trephination

The procedure of trephination is understood to have a significant history in Africa, with traces pointing to its origin from the Arabs. It is practised by many groups that include among others, the Kisii and Tende in Kenya and Tanzania, Uganda, South Africa, Nigeria, and Somalia. Although the procedure dates as far back as human history itself, the first discovery of the trephined skull was made by After Prunires' at Aiguires in 1868 (Rawlings III & Rossitch Jr, 1994). It is regarded as the oldest form of a surgical procedure and entails the removal of a piece of bone from the skull by scraping, grooving, boring or cutting (Gross, 2012). In ancient cultures, trephination was administered for mystic and religious reasons as well as a treatment procedure for severe headaches, madness and other chronic conditions. It was carried out with great caution to avoid tampering with muscles, brain meninges and the brain (André, 2017). The procedure also demonstrated its effectiveness in the management of epilepsy and head trauma. In the latter, the administration of trephination was intended to relieve the pressure on the brain resulting from the fracture, remove bone shards and drain haematomas (Collado-Vázquez & Carrillo, 2014). Trephination was performed for ritualistic purposes though it has some therapeutic significance as Balcells (2014) argues.

The usefulness of trephination slowly faded away due to the development of newer means for the management of mental health problems. This transformation came with the introduction of more methods and useful items that were used in the management of mental illness. After that, more diverse systems and practitioners emerged, such as religion, the adoption of the allopathic health system and the rapid growth of African traditional medicine.

3.6 African traditional medicine and its application

Every society has its systems that refer to the maintenance of health and wellbeing (Figueras & McKee 2012) which are further influenced by cultural differences and cultural references to health and illness (Van Rooyen, Pretorius, Tembani, & Ten Ham, (2015). South Africa, like other African countries, has a pluralistic system of healthcare,

which encompasses the coexistence of the non-conventional health systems such as the traditional and religious systems and the modern or western medicine systems. African Traditional Medicine is playing a crucial part in the management of health, holistically, in either a preventative, curative and/or palliative nature (Mothibe & Sibanda, 2019).

According to the Draft Policy on African Traditional Medicine for South Africa, African traditional medicine is described as:

> A *body of knowledge that has been developed and accumulated over tens of thousands of years, which is associated with the examination, diagnosis, therapy, treatment, prevention of, or promotion and rehabilitation of the physical, mental, spiritual or social well-being of humans and animals* (Mothibe & Sibanda, 2019; p. 6).

The African population may consult the two systems concurrently, their help-seeking pathways often begin by simple self-help methods that may include self-medication, diet alteration, lay referrals which may, if deemed unsuccessful, be followed by consultation with either the allopathic or traditional health practitioner (Van Rooyen *et al,* 2015).

Van Niekerk (2012) and Johnson (2019) gave an estimate of between 200,000 and 300,000 traditional health practitioners in South Africa whose categories are recognized by the Traditional Health Practitioners Act No 22 of 2007. Different categories of traditional health practitioners include herbalists, diviners, prophets or faith healers, traditional surgeons and traditional birth attendants or traditional midwives. These are discussed below.

3.6.1 Herbalists

Ross (2010) describes this category of healers as ordinary individuals who have acquired an widespread knowledge of herbal treatments which further enables them to diagnose illness and prescribe herbs, medication and enemas for a range of ailments, offer protection against witchcraft, avert misfortunes and bring prosperity and happiness. They often use African medicinal plants, animal products and patent

medicines in preparation of their concoctions which usually has a protective and healing effect. Unlike diviners, herbalists do not necessarily get a calling towards their professions (Kahn and Kelly, 2001). In some areas, they may wait for their clients to come to them, or they may operate in business districts where they sell their medicinal products aimed at different uses.

3.6.2 Diviners

This involves the type of healers that use divination, or the throwing of divination bones, cards or stones to the floor in a way of communicating with their ancestors. These individuals can understand the problem at hand by their interpretation of how the bones would have fallen, with some even entering into a trance-like state of altered consciousness as they commune with their ancestors (Ross, 2010). They are often referred to as spirituality experts through their capacity to diagnose and define illness, its derivation and the reasons thereof, referring to the African belief system (Sobiecki, 2014; Semenya and Potgieter, 2014).

The divination bones they often use is a set of various small objects ranging from shells, dice, tiny animal bones to plant kernels, signifying various units in the spiritual milieu. When thrown to the ground, these bones usually fall in a certain pattern specific to the patient as intended by the patient's ancestors, to deliver a specific message to the patient. The diviner may then interpret the pattern as it applies to the patient or the situation at hand. Diviners are also known for their ability to interpret the messages that ancestors send to the living through dreams (Cumes, 2013).

Foden (2009) differentiates this category, of healers often referred to as '*sangomas"* from the other category referred to as *"inyangas"* in the sense that the former administers healing in various ways which may have been acquired through their training, lengthy apprenticeship and initiation ceremony, while the latter is more of a herbalist without any formal initiation ceremony. The word "*sangoma"* is a Zulu word that is used to refer to a drum whose sound is believed to be the one that brings forth the spirit Cumes and Barbara (2010, 2). In addition to their duties, the diviners are also able to act as mediators between a person and his ancestors ('*izinyanya in xhosa*') who

may cause illness or calamity if displeased. They are further often called into their profession through a sickness of their own known as '*thwasa'* after which they undergo a three- to five-year-long training process under the guidance of another diviner (Kahn & Kelly, 2001).

3.6.3 Prophets or faith healers

Faith healers are oftentimes referred to as '*abathandazi',* follows the religious approach of the African Independent Churches that carries out the diagnosis and treatment through prayer, candlelight or water as well as the inhalation of the vapour of substances poured over heated stones (Ross, 2010; Devenish, 2003). As much as the acknowledgement of this category towards Christianity, it encompasses both the African cultural cosmology and Christianity through its practice. In the same light, prophets operate from the religious approach as foretellers of thoughts, major events and diseases and are usually consulted for guidance (Kahn and Kelly, 2001).

3.6.4 Traditional surgeons

This encompasses a category of healers who are recognised by traditional authorities, such as chiefs, to perform circumcision on boys (Mokgobi, 2014; Devenish, 2003). In African history, men of a particular age were taken through the process of initiation into manhood which involved circumcision and the instilling of African traditional customs, values and social expectations into them. This whole process was under the directorship of the traditional surgeons and senior male citizens as they are regarded as the custodians of African and traditional history as per their different settings.

3.6.5 Birth attendants or traditional midwives

This category comprises middle-aged or elderly women who may not necessarily possess any formal training, who attends to women during pregnancy, labour and the postnatal phase through the use of herbs that facilitates the process of delivery and gives the necessary attention post-delivery (Owens-Ibie, 2011). Such women may have accumulated their expertise over time through witnessing, experiencing and assisting

throughout the delivery process, and through the transference of such skills to them by their previous generations (Mokgobi, 2014).

3.7 The initiation process of traditional health practitioners

Much as there are processes undertaken for the training of conventional health practitioners, the case is similar for traditional health practitioners. Although it may be a matter of choice for one to become a western-oriented health practitioner, the issue is different in the case of traditional health practitioners, wherein some, if not in most cases, the element of choice is diminished. Literature suggests that most healers receive a calling from their ancestors to become traditional health practitioners. The authenticity of which has to be made by a diviner, who then guides in respect of the choice of the trainer to conduct the initiation process. This process may not be done by any healer except the one called to do so (Mokgobi, 2012). The difference in the types of traditional healers distinguishes the different types of training they go through, as well as the length of time it may take, which may range between months and years depending on the speed at which the initiate learns the trade (Peek, 1991).

The process of initiation encompasses the initiate moving into the homestead of the trainer, where they become part of the family. The learning process includes the interpretation of bones, communication with the ancestors, types of illness and their healing methods, as well as the plant and animal extracts used for healing, among others (Mokgobi, 2012). The initiates further learn practices that inform their conduct which is inclusive of, but not limited to, their sexual conduct and the way they greet others and interact with them (Hammond-Tooke, 1989; Mokgobi, 2012). The initiation process may at times be costly for the initiates, with cattle, sheep and oftentimes, money being used as items of payment (Campbell, 1997). When the initiation process is completed, final rituals are performed as a way of releasing the healer back into their respective communities to commence with their responsibilities. During such a reintegration, the initiate is tested on their abilities to communicate with their ancestors and interpret their commands, failure to, which may result in the extension of the training period (Mutwa, 2003; Mokgobi, 2012).

Sebata (2015) asserts that traditional health practitioners play numerous roles that may include the healing of spiritual troubles and social disharmony as well as the mediation process between the living and the ancestors. They are believed to communicate with the ancestors and receive guidance through their interpretation of dreams and the throwing of bones which usually occurs in a sacred place called ‘ndumba’.

3.8 Conclusion

This chapter aimed to give an outline of the worldview of health and illness from an Africa point of view with special reference to the causal factors, conceptualisations, types of mental health problems and culture-specific syndromes, the treatment processes of mental illness, the types of traditional health practitioners and the initiation process they undergo. The diversity in the health management systems that exists within the South African context ascertains a positive contribution towards the quality of life of its people. These coexisting systems seem to complement one another, therefore raising an ongoing debate about collaborating them, especially the western and the African health system, which the next chapter will focus on.

CHAPTER FOUR

VIEWS ON THE COLLABORATION OF THE WESTERN AND AFRICAN TRADITIONAL APPROACHES

4.1 Introduction

Due to the acknowledgement and the high rate of utilisation of African traditional medicine in South Africa, this makes the traditional health practitioners active participants in the health and wellbeing of the people of South Africa. With this in mind, there has been growing literature on the advocacy of collaboration of African traditional medicine into the mainstream health structure. This chapter aims to give an overview of the concept of collaboration, the rationale of collaboration, the role of African traditional medicine in South Africa, and the possible challenges that may impede the process of collaborating these two systems.

4.2 The concept of collaboration

There is an existing body of evidence that suggests that the concept of collaboration has been used in different settings to refer to different phenomena. Oftentimes, this concept is confused with cooperation, further making the two concepts indistinguishable to many people (Camarihna-Matos & Afsarmanesh, 2008). Collaboration is understood to entail information, resources, and responsibilities that are shared among entities to plan, implement and evaluate an activity program to achieve the desired goals (Lai, 2011). Strong and highly interdependent relationships are the main focus in the process of collaboration (Keast, & Mandell, 2009).

The concept of collaboration may be defined differently based on the context in which it is used. However, despite the different contexts, the common features are shared across. Camarihna-Matos and Afsarmanesh (2008) present the term collaboration as a derivative of the Latin '*collaborare'* which means 'working together'. They further define the term as: "A process in which entities share information, resources, and responsibilities to jointly plan, implement, and evaluate a program of activities to achieve a common goal". The Council on Environmental Quality (US) (2007) delineates

collaboration in environmental management as a process where groups with diverse interests unite intending to address management issues that affect a specified geographical area.

For this study, the researcher focused on understanding collaboration between the western and African traditional health systems in the provision of healthcare services to communities.

4.3 Rationale for collaboration

WHO (2009) and Latif (2010) categorizes the idea of integration from three different perspectives. Firstly, integration may denote the incorporation of traditional medicine into the national health care system through the utilization of traditional medicine in the mainstream health care system. Secondly, integration may mean the incorporation of the practice of traditional medicine with that of modern medicine through the incorporation of traditional remedies into the normal day to day routines of the western biomedical practitioners. Lastly, integration may refer to the integration of traditional and contemporary medicine as two individual branches of medical science.

According to Wamba and Groleau (2012), the incorporation of the religious, African traditional and western healing practices seems like an inevitable exercise especially in most African countries, with a particular interest in Cameroon where this integration exists, though without any formalization. The idea is further enforced by the shortage of western-oriented healthcare practitioners and the inaccessibility of such practitioners due to geographical and economic factors, particularly in Malawi (Lampiao, Chisaka & Clements, 2019). Though the religious and biomedical systems exist independently from each other, some biomedical practitioners often engage informally with the African traditional practitioners in Cameroon. The integration was further supported by the move for the indigenous peoples' advocacy for their right to retain their cultural beliefs and traditional medicine practices which further propelled the espousal of the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP) in 2007 (Carrie, Mackey & Laird, 2016).

4.4 The role of traditional medicine in South Africa

African traditional medicine plays a key role in the management of health, holistically, and in either a preventative, curative and/or palliative nature (Mothibe & Sibanda, 2019). Traditional healing practices existed in Africa long before conventional medicine, and beyond the attempts by majestic governments and early religious missionaries to suppress it (King, 2002). For as long as African traditional medicine has existed, it has always been praised for its accessibility, affordability and at times, its monotony (Mahomoodally, 2013). South Africa is one of the African countries that have always and still recognize and utilize the services of traditional health practitioners.

According to Latif (2010), the estimations by the South African Department of Health suggests that about 80 percent of South Africans consult with traditional health practitioners before consulting with western modern medicines. Mokgobi (2013) further asserts that there is a shortage of western-trained healthcare practitioners in the district health facilities and clinics in South Africa and an abundance of traditional health practitioners in both urban and rural areas in the country, which informs the government's support of the idea of the integration of the two systems. This acknowledgement of the coexistence of both the traditional and western healing systems has brought about a move towards the development of the model of collaboration of the two systems (Campbell-Hall *et al,* 2010). The literature further acknowledges the tensions that continue to lead the scenery of research and policy debates on the role of traditional health practitioners, chiefly regarding historical injustices, scientific gaps, medicine toxicity as well as the mistrust by biomedical practitioners (Moshabela, Zuma, & Gaede, 2016). There is, so far, little knowledge about the practices of traditional health practitioners and how their practices may be aligned with the western healing systems for a collaborative and comprehensive health system (Menze, Van der Watt, Moxley, & Seedat, 2018).

4.5 Possible challenges in the process of collaboration

Although many advocates for the collaboration of the two healthcare systems, there are still some doubts on the possibility of the envisaged collaboration. Some people support

the integration while some resent the idea altogether. In a study that was conducted by Opoku, Addai-Mensah and Wiafe, (2013) which was aimed at understanding people's perceptions on the fusion of the two health systems, there is an acknowledgement of those who support the idea while others disfavour it, particularly on the elements of trust and respect between the two systems.

One of the first major challenges that threaten the association of traditional and western health systems is the channel of referrals. This was ascertained by the findings of the study by Sorsdahl, Stein and Flisher (2010) who argue that traditional health practitioners have shown their preference in referring to other traditional health practitioners based on their strength and the quality of their ingredients for making their medicines.

Secondly, another contributory factor to the resistance of biomedical practitioners towards the idea of collaboration is the lack of trust that they have in traditional medicine. The World Health Organisation (2000) has cited that there seems to be less respect for the traditional health system by the western biomedical system, which further minimizes the utilization and exploration of the benefits presented by each model. Campbell-Hall *et al* (2010) allude that the collaboration of western and traditional health practitioners is somewhat impeded by a lack of mutual respect of traditional health practitioners by western practitioners, making it look like the latter are mere assistants of the former. Traditional health practitioners further feel that the western biomedical practitioners do not want to work with them because they doubt the traditional health practitioners' effectiveness and do not value them as health professionals (Sorsdahl, Stein and Flisher, 2010). There is a demonstration of ignorance of traditional medicine by western biomedical practitioners, which is associated with their mistrust and disrespect towards traditional health practitioners (Hlabano, 2013).

According to Latif (2010), another factor that is likely to work against the idea of collaboration is the doubt that the western biomedical practitioners have about the lack of scientific evidence in traditional medicine, which further contributes to the lack of trust

in its safety and effectiveness. This is supported by Van Rooyen, Pretorius, Tembani and ten Ham (2015) who discusses the non-scientific processes of traditional health practitioners as not handwashing, non-sterile equipment, lack of measurements in their prescriptions and medicines with consideration of differing patient characteristics.

Thirdly, other scholars hold the view that the collaboration of the traditional and western health systems may still be far, based on one system rejecting another. This is highlighted by WHO (2000) which indicates that the various responses that were received about the idea of harmonization of the two systems, citing the rejection of one health system by another and parallel existence with minimal or no communication over patient care. Traditional medicine is further condemned due to the negative views that the biomedical practitioners hold about it as characterized by “unregulated, intuitive and dangerous practices that lend themselves to deferred access, high healthcare costs, herbal toxicity, bogus practitioners, ‘muti’ murders and witch-hunts” (Moshabela, Zuma, & Gaede, 2016; p. 89).

Lastly, Opaneye and Ochogwu (2007:68) argue that another challenge that hinders collaboration between traditional health practitioners and western biomedical practitioners is the differing views which the two systems hold about causation. The former views illness causation as emanating from physical causes while the latter incorporates spiritual causal factors in their approach to enquiry and management.

4.6 Conclusion

This chapter was aimed at giving a synopsis of the issues on the collaboration of western and African traditional approaches in health. The concept of collaboration was defined. The chapter further discussed the rationale for collaboration, the role of traditional medicine in South African as well as the possible challenges that are envisaged in the process of collaboration. The next chapter will discuss the theoretical framework for the study.

CHAPTER FIVE

THEORETICAL FRAMEWORK

5.1 Introduction

This chapter aims to outline the theoretical framework that has guided the study. The researcher has used the biopsychosocial and Afrocentric theories as lenses to understand case formulation of mental health conditions by Western-trained and traditional health practitioners, as well as the Afrocentric theory to look into the understanding and conceptualisation of mental disorders from the perspective of the African traditional health practitioners. The choice of the two theoretical lenses is intended to have room for the epistemological foundations that underpin the different two health systems.

5.2 Theoretical orientations

Over the years, there have been many debates on what 'theory' is, suggesting that it is a complex concept to define (Udo-Akang, 2012; Speaks, 2016). According to Abend (2005), a theory can be understood as a perspective through which one sees and interprets the world and various social phenomena. Wacker (1998) emphasises the importance of theory-building through its ability to provide a framework for analysis and efficiency in the development of the field. Theory-building is important because it provides a framework for analysis, facilitates the efficient development of the field and its need for applicability to practical real-world problems. A good theory further follows the criteria which include among others uniqueness, cost-cutting, conservation, generalisability, richness, internal consistency, empirical riskiness, and abstraction, which apply to all research methods. Udo-Akang (2012) further describes the systematic nature of theory as it aims to give an justification of a problem, to describe the distinguishing features of a phenomenon, and to provide predictive utility, further making research without theory without basis. The theory itself depends on research to provide proof for its correctness. The researcher has opted to use both the biopsychosocial and the Afrocentric theories as a lens in the present study.

5.2.1 The biopsychosocial theory

The researcher will use the biopsychosocial theory to understand how clinical psychologists understand the clinical conditions reflected in the case vignettes. The theory will further aid the researcher to understand and carry out the management of such conditions. The choice of the biopsychosocial theory for the present study was informed by the shortfalls of the other western-oriented theories which were discussed in chapter two, which often look at individuals and phenomena from either the psychological, social and biological domains in isolation. The biopsychosocial theory has proven itself to be a theory that acknowledges the interplay of psychological, social and biological aspects in the understanding of psychopathology. The literature further suggests that it has proved itself to be effective in the psychological management of mental disorders.

The choice of the biopsychosocial theory was further prompted by the acknowledgement of its ability to advocate for a multidisciplinary approach to the management of mental health issues. Furthermore, it is commended for its integrative and holistic approach to mental illness and its discouragement of the mind-body split that was the case with the biomedical approach (Babalola, Noel & White, 2017). The applicability of this theory has been echoed by Hulla, Brecht, Stephens, Salas, Jones and Gatchel (2019) due to its effectiveness in the management of pain and its association with physical deconditioning, postural control, gait, sleep quality, and psychosocial well-being. This theory was also found to be valid, especially in medicine and psychiatry, on the account that it denotes the reality that mental illness is caused by multi-level mechanisms at the biological, psychological and social levels (Tripathi, Das, & Kar, 2019).

5.2.1.1 Historical developments of the biopsychosocial theory

The biopsychosocial theory is a product of George Engel's work as a deviation from the commonly used biomedical model which only focused illness causation on biological and chemical factors. Engel believed that the biomedical model was reductionistic, further proposing and advocating for a holistic approach anchored in the general

systems theory to address health-related issues (Henriques, 2015). Without any denial or ignorance of the advances in medicine that the biomedical research has fostered (Gatchel, Howard, Haggard, Contrada, & Baum, 2011), Engel developed the Bio-Psycho-Social theory in 1977 with the view that, unlike the bio-medical model which considered only biological factors in understanding illness, to understand and respond satisfactorily to patients' suffering, and to give patients a sense of being understood, clinicians had to acknowledge the interplay of psychological and social dimensions of illness (Borrell-Carrió, Suchman, & Epstein, 2004).

Engel believed that as a medical illness became more chronic, the psychological and social factors in the form of either distress, illness behaviour, or the sick role often have a role in the complication of the assessment and treatment process (Gatchel, Howard, Haggard, Contrada, & Baum, 2011). The theory was later applied in different settings including research on pain, where the pain was viewed as a dynamic interaction of the biological, psychological and social factors which may on many occasions differ from one individual to another (Gatchel, Howard, Haggard, Contrada, & Baum, 2011). The theory also brought about developments in medicine and psychiatry in the last decades of the 20th century through new ways of conceptualizing mental health challenges and brought about changes in research, medical teaching and practice (Babalola, Noel, & White, 2017).

5.2.1.2 The biopsychosocial view of illness

The biopsychosocial theory is one of the biomedical models that emphasise the interplay of the biological (genetic predisposition), psychological or behavioural (lifestyles, explanatory styles, health beliefs), and social factors (family relationships, socioeconomic status, social support) tenets in the clarification of pathogenesis and health aetiology (Hatala, 2012). This theory explains that all three domains play an equal part in the manifestation of all the health situations and that none of them may be used in isolation to elucidate any patient or pathology with the exclusion of the other two (Ghaemi, 2009). This model further asserts that the determinants for, and the prognosis of, mental health difficulties are the result of an interaction between biological,

psychological, and social factors with no factor having a “monopoly” on the explanation and/or cure (Babalola, Noel & White, 2017).

As the biopsychosocial approach was anchored on the primary tenet that mental illness was a reaction of the personality to biological, psychological and social factors, Michael Wilson outlined the basic assumptions of the bio-psychosocial model. He argued that:

> “(i) the boundary between the mentally well and the mentally ill is fluid because normal persons can become ill if exposed to severe enough trauma; (ii) mental illness is conceived along a continuum of severity – from neurosis to borderline conditions to psychosis; (iii) the untoward mixture of noxious environment and psychic conflict causes mental illness; and, (iv) the mechanisms by which mental illness emerges in the individual are psychologically mediated (the principle of psychogenesis)” (Wilson, 1993; Makgabo, 2013: 20).

In the assertion made by Kinderman, (2005) a disruption in psychological or cognitive processes contributes as a pathway to the development of mental illness. Therefore, positive interaction between the biological and social factors together with a person’s individual experiences may guide to mental illness through their interplay with those disrupted psychological processes. Papadimitriou (2017) emphasizes in addition to biological factors, the role of environmental factors in increasing the probability of the clinical expression of a mental illness and the role they may have on the time of onset of illness manifestation. Though the adoption and implementation of the biopsychosocial approach in the primary care settings grow fairly slowly, this approach has been deemed imperative through its likelihood to improve clinical outcomes for chronic diseases and functional illnesses seen in the primary care settings (Kusnanto, Agustian, & Hilmanto, 2018).

5.2.1.3 The biopsychosocial management of illness

Unlike the previous one-sided biomedical model, the biopsychosocial model advocates for a multidisciplinary advance to the management of illness that should take into cognisance, the biological, psychological and social domains of a human. In the

assertion made by Cardoso (2013) the biopsychosocial approach has proven effective and with many benefits for clinical workers, especially when treating mental illness. It enhances the ability to treat the patient holistically and fosters the patient's ability to gain self-awareness and the interplay of several parts that function together in their health. Schotte, Van Den Bossche, De Donker, Claes & Cosyns, (2006) argues that the biopsychosocial approach has proven its effectiveness in the management of depression. The biological management encompasses the stabilisation of underlying medical problems, substance-related disorders and primary psychiatric symptoms with medication and electroconvulsive therapy. Psychotherapy is then incorporated to addressing psychological symptoms while the assessment and referrals to relevant stakeholders for social support addresses the social aspects of depression.

5.2.2 The afrocentric perspective

This study has used the Afrocentric theory as espoused by Molefi Kete Asante to comprehend mental health conditions as explained by the traditional health practitioners from an African cultural point of view. This is the theory through which conceptualisations from traditional health practitioners could be understood. Unlike many other theories, the Afrocentric theory has preserved Africanism through its ability to put Africans at the centre of African reality. The theory further makes Africans the main agents in the interpretation of African cultural issues, habits, religion and values in a manner that is sensitive and represents them without creating room for bias and non-African superiority over African inferiority. This will assist the researcher to understand the selected mental health conditions from the perspective of the participants themselves, without any undue influence of the non-African approaches and practices.

5.2.2.1 Historical developments of the afrocentric perspective

Many scholars have attempted to understand the phenomena that affect the lives of people of African descent through the use of Eurocentrically-oriented methods of enquiries that served the Eurocentric interests. Contrary to that, some scholars had an interest in exploring similar phenomena by placing the African people at the centre of their enquiries. These developments have brought about the coining of the term

“Afrocentricity” by Molefi Kete Asante in the second half of the twentieth century to civilise and enlighten the African Americans and also to arouse their consciousness as they suffered more segregation, shame and an inferiority complex (Khokholkova, 2016).

Although the roots and the origin of the Afrocentric philosophy cannot be established with certainty, there is a need for the acknowledgement of Marcus Garvey as one of its most influential propagators (Chawane, 2016). Before the concept of “Afrocentricity” could be brought to light by Asante, the proposal of black identity and self-determination in politics, culture, socioeconomic and psychological issues have been there with due credit to early scholars such as W.E.B. Du Bois, Marcus Garvey, Kwame Nkrumah and Cheikh Anta Diop among others (Kumah-Abiwu, 2016). The development of the Afrocentric ideology was prompted by the distortion of African identity and the loss of cultural values and practices that was consequential to colonisation (Chukwuokolo, 2009). In recent years, the expression of an African-centered paradigm has gained momentum in becoming an important part of the social science research published on African descendants (Cokley & Williams, 2005).

5.2.2.2 The definition and overview of the afrocentric perspective

Afrocentricity emerged as a concept that combined theory and practice, social movement and research methodology, culture and lifestyle to rehabilitate blacks globally (Khokholkova, 2016). Many scholars have attempted to define the concept of Afrocentricity. The common denominator in their definitions is the element of placing African descendants as agents at the centre of issues that concerns Africa.

Keto (1989) defined the African-centered perspective as an approach that rests on the foundation that sees validity in positioning Africa as a geographical and cultural base in the enquiry of the descendants of Africa. Karenga (1993, as cited in Bangura, 2012) defines Afrocentricity as a quality of thought and practice that is rooted in the cultural representation and human interest of African people. Goggins (1996, as cited in Bangura, 2012) defines the concept as the ability to construct and use frames of reference, cultural filters and behaviours that are consistent with the viewpoints and heritage of African cultures to advance the interests of African descendants. Gray

(2001, as cited in Thabede, 2008) defined the term ‘Afrocentric’ as an idea and perspective which maintains the ability of African people to see, study, interpret and interact with people, life and reality from the perspective of African people other than from the perspective of non-African people or African people who are alienated from Africanness.

For this study, the researcher relied on the following definition of afrocentricity by Molefi Asante:

> ..a mode of thought and action in which the centrality of African interests, values, and perspectives predominate. In regards to theory, it is the placing of African people in the centre of any analysis of African phenomena. Thus, it is possible for anyone to master the discipline of seeking the location of Africans in a given phenomenon. In terms of action and behaviour, it is a devotion to the idea that what is in the best interest of African consciousness is at the heart of ethical behaviour. Finally, Afrocentricity seeks to enshrine the idea that blackness itself is a trope of ethics. Thus, to be black is to be against all forms of oppression, racism, classism, homophobia, patriarchy, child abuse, paedophilia, and white racial domination (Asante, 2003: 2).

This definition endorses the assertion that Africans themselves, including their experiences should be at the hub of analysis, thereby removing Europe from the centre of the African reality (Asante, 1998; Mazama, 2003). The Afrocentric approach anchors itself on cultural and social realities that stress familiarity with history, language, philosophy and myths of Africans in their framework (Mkabela, 2005). The emergence of the Afrocentric perspective has brought with it developments in the field of psychology as espoused by Williams (1975) who identified its purpose through its introduction of definitions, conceptual models, tests, and theories of the normative behaviours that are informed by the experiences of people of African ancestry.

5.2.2.3 Afrocentric Conceptualisation of illness

The emergence of the Afrocentric perspective denounces the European culture which has always served as the basis for social life further regarding any form of deviation from their norms and standards as illegitimate and pathological. This approach redefines and brings forth the new models and conceptions of social life and refers to the historical and contemporary centrality of Africa (Jackson II & Hogg 2010). In the assertion by Behr and Allwood (1995), the traditional Africa perspective considers numerous events such as God, ancestors, pollution and witchcraft as causations to illness.

5.2.2.4 Afrocentric views on the management of illness

Theories such as the Afrocentric theory have played a significant advocacy role for the African practices as augmented by Benedict (2014) who suggests that African indigenous medicines which have been neglected for a long period have been resurrected due to their rising demand in contemporary times. This was further rubberstamped by the findings of the study by Ali (2016) who advocates for the incorporation of an Afrocentric curriculum into psychotherapy to help African-American men to gain the awareness of self, culture, self-hatred as well as the history of their oppression to gain success and overcome these obstacles. Jackson II and Hogg (2010) further argues that the Afrocentric theory would privilege a model of healing that is communal that apart from focusing on individuals, goes further to view individuals within the prospects of a larger social and cultural collective which is the cornerstone of African practice.

5.3 Conclusion

In this chapter, the researcher presented an overview of the theories that guide the study. The Biopsychosocial theory and the Afrocentric theory were discussed in respect of their historical background and their views on the conceptualisation and management of mental disorders. The Biopsychosocial theory was deemed relevant in outlining the clinical psychologists' conceptualisations of mental disorders from a western

perspective which was also the case with the participants in this study. The Afrocentric theory, on the other hand, has proved to be effective as it gives the framework of the conceptualisations of traditional health practitioners' views of mental disorders within the South African context. The next chapter will discuss the methodological processes that the study followed.

CHAPTER SIX

RESEARCH METHODOLOGY

6.1 Introduction

This chapter presents an outline of the methods that this study followed to answer the research question which was outlined in the first chapter of the study. The chapter presented the epistemological and ontological issues that gave shape to this study. The research method, research design, sampling methods, data collection and analysis methods, quality criteria and ethical issues were discussed. The next chapter will discuss the findings of the study, with more emphasis on the themes and subthemes that emerged.

6.2 Epistemological and ontological foundations of the study

The research followed the **constructivist/interpretive** paradigm and an **idealistic** ontology through the process of the study. The constructivist/interpretive paradigm is a learning or meaning-making theory of knowledge that concerns itself in explaining the nature of knowledge and how human beings learn and accumulate that knowledge. Its focus is more on the cultural embeddedness of learning (Mogashoa, 2014). It asserts that people create their own understanding and knowledge of their world through how they experience things and their reflection of those experiences, further arguing that people construct what they learn regarding their experience (Adom, Yeboah & Ankrah, 2016). To the researcher, this denotes that the conceptualizations of the traditional health practitioners and clinical psychologists will depend on the knowledge, of their learning and accumulated experiences to study the selected cases.

This study was informed by the idealistic ontology. In the words of Al-Saadi (2014), ontology refers to the human beliefs about the nature of reality and the social world, and whether there is a shared social reality or multiple context-specific realities. There are two main divergent ideological constructs, namely realism and idealism. The realists argue that there is an external reality that exists independent of our beliefs and our understanding of it while the idealists believe that there is an external reality that is

fundamentally mind-dependent, predictable through the human mind and socially constructed meanings (Ritchie, Lewis, Nicholls & Ormston, 2013). In the context of the present study, the researcher has followed the idealist ontology to find out about the formation of reality from the conceptualisation of clinical psychologists and traditional health practitioners on the selected cases.

The researcher has chosen the constructivist/interpretive paradigms with the assumption that the knowledge accumulated is dependent on the learning processes that refer to the cultural pillars within which this process of learning takes place. The researcher acknowledges that reality formation is dependent on the level of the knowledge accumulated and engrained, which makes sense in the cultural context within which it was learned. The inherent knowledge accumulated does not change, but may differ in terms of one case or incident to another. Therefore, meaning and conceptualisation may differ due to one's interpretation of it regarding one's innate view of reality that may have been learned within that context. The idealist ontology was chosen to understand how clinical psychologists and traditional health practitioners make sense of the reality they perceive about the selected mental disorders. Therefore, mental disorders will be understood in relation to how they are conceptualised by clinical psychologists and traditional health practitioners as they make reference to their reality and the context within which that reality was formed and the amount of accumulated knowledge that informs that reality.

6.3 Using a qualitative approach in the present study

This study has opted for the qualitative research method. This is a form of social action that concerns itself with how people infer and make sense of their experiences, intending to understand the social reality of individuals. The study is exploratory further seeking to explain 'how' and 'why' particular social phenomena operate the way they do in certain contexts (Mohajan, 2018). Qualitative research studies human behaviour in its natural settings by using people's descriptions as data without the researcher's manipulation of the emerging variable under investigation (Hancock, Windridge & Ockleford; 2007). Qualitative research is not statistical, further incorporating multiple

realities. It is often preferred over quantitative research through its flexibility and ability to produce detailed descriptions of participants' feelings, opinions and experiences for further interpretation of the meaning of their actions (Rahman, 2017).

6.4 Research design

As is the case with every project, there has to be a structure that often guides the plan that the entire process should follow. This is the same with research in which the structure comes in the form of a research design. This is the element of research that aims to ensure that the evidence that is derived through the research process enables the researcher to answer the initial question without any ambiguity (de Vaus, 2001). This is the conceptual blueprint within which the research is conducted, and if it is well chosen, further enhances the validity and accuracy of the conclusions made from that research (Akhtar, 2016). In qualitative research, a design implies the general way of thinking about researching the description of the purpose of the study, the researcher's role, the research stages and the data analysis and presentation methods (Astalin, 2013). For this study, a case study design was chosen.

According to Phelan (2011), the case study is a research method that allows for an in-depth review of new or uncertain phenomena whilst retaining the holistic and meaningful characteristics of real-life events. The case study method was selected as it allows the researcher to compare the formulations of the same cases by participants from two diverse approaches. The researcher envisages following the hypothesis-generating type of case study method which concerns itself with comparing some cases or testing the same cases on different approaches to developing more general theoretical propositions (Levy, 2008). Two cases; depression and schizophrenia were chosen and tested on a group of traditional health practitioners and clinical psychologists.

6.5 Sampling

A sample of twelve (12) Northern Sotho speaking participants (traditional health practitioners = 6; clinical psychologists = 6) were selected through convenience

sampling. According to, Musa and Alkassim (2016), convenience sampling is a type of non-probability or non-random sampling that entails situations where members of the target population that meet certain practical criteria, such as easy accessibility, geographical proximity, availability at a given time, or the willingness to participate are included for the purpose of the study. The researcher has also sampled two vignettes of Major Depressive Disorder and Schizophrenia that will be used to collect data. For this study, all the participants were conveniently drawn from the Polokwane Municipal area. The identified geographical area for the study was selected due to its accessibility to the researcher. In addition, the targeted population predominantly speaks Northern Sotho, which is also the language spoken by the researcher. The researcher aimed to minimise misinterpretation due to language barriers.

6.6 Data collection

Two data collection methods were used, namely case vignettes and semi-structured interviews. A vignette is a brief, carefully written description of a person or situation designed to simulate key features of a real-world scenario (Evans, Roberts, Keeley, Blossom, Amaro, Garcia, Stough, Canter, Robles & Reed, 2015). They are used to elicit information about the participants' own set of beliefs (Gourlay, Mshana, Birdthistle, Bulugu, Zaba & Urassa, 2014). For this study, the researcher used two vignettes that represent cases of major depression and schizophrenia as defined in Western nosological systems such as the DSM-5 and ICD10. The vignettes were sourced from Austin, Bezuidenhout, Botha, Du Plessis, Du Plessis, Jordaan, Lake, Moletsane, Nel, Pillay, Ure, Visser, Von Krosigk, and Voster (2015, p. 121, 204), and adapted by the researcher to ensure that they are easily understood by both traditional and western trained health practitioners (See Appendix 2A and 2B for the vignettes – English version). To ensure validity, the case vignettes were translated into Northern Sotho by one language expert, and later back-translated into English by another language expert. In addition to the case vignettes, the researcher used semi-structured interviews to elicit responses from the participants to explore the assumptions that they have made (based on the case vignettes) in respect of the causes, the presentation and the treatment approaches that they consider appropriate. Each participant was interviewed on the first

and second vignette. The vignettes were presented on the interview day to avoid the participants accessing the cases beforehand as it may create room for contamination of responses. The responses were audiotaped for analysis purposes.

The audiotaped data was transferred to a computer in which they were kept within a password-encrypted folder to ensure confidentiality. The handwritten notes and memos as well as the consent forms which were signed by the participants were kept under lock and key. The data that was collected from traditional health practitioners were transcribed into Sepedi as this is the language that was preferred by the participants. The transcribed data was sent to the translator to be translated into English for purposes of analysis. The data that was collected from clinical psychologists were transcribed into English as it was the language through which data was collected. The transcripts were also stored on a computer in a password-encrypted folder for security purposes.

6.7 Data analysis

The following steps of thematic content analysis (TCA) as recommended by Braun and Clarke (2006), were followed:

- **Step 1: Familiarisation with the data:** It is during this stage when the researcher is required to immerse himself in the data aiming at understanding the depth and breadth of the content. This involves multiple readings of the data, and a search for the meanings and patterns. During this stage, the researcher aims to familiarise himself with the aspects of the data. If the researcher is working with verbal data, this is the point where the data has to be transcribed. Similarly, in the present study, the researcher began by transcribing the data which was later sent to the language expert for translation. The researcher read the text data to familiarize himself with the aspects that the data encapsulated as well as extracting the ideas that emanated from it for purposes of analysis.

- **Step 2: Generating initial codes:** This stage builds on the first one, where the researcher would have read and familiarised himself with the data and having

listed the ideas that emanated from the data. During this stage, in the context of this study, the researcher developed codes, which were to identify features of the data that appeared interesting for analysis. The coding process involved the organisation of data into meaningful groups. The researcher followed this stage by breaking down the raw data into meaningful codes from which themes were developed.

- **Step 3: Searching of themes:** The researcher moved on to the third stage during which he used the coded and collated data to develop some themes from them. At this stage, the analysis broadened to the level beyond coding where the researcher developed themes and subthemes from the coded data according to the relationship of such codes. The researcher further collated the themes and subthemes with some extracted quotes from the raw data as a way of explaining these themes in a more meaningful way.

- **Step 4: Reviewing of themes:** In this stage, the researcher looked for coherence between the themes and the extracts that are paired with them. The researcher also looked at whether the themes represented the data well; whether there is a need to join some themes into one; or, whether a theme should be split as indicated by the representative data, and so on.

- **Step 5: Definition and naming of themes:** The researcher moved to the next step of the analysis which involved the definition and refinement of themes to present them for analysis. This is the step during which the researcher identified the essence of what each theme is about, further determining each aspect of the data that each theme captures.

- **Step 6: Production of the report:** During this stage, the researcher presented the narrative analysis of themes, putting the more complex data in a simple form for the readers. This further entailed the inclusion of extracts from the data as examples that were meant to support the arguments without any deviation from the research question.

6.8 The development of an explanatory model

This study aimed to develop a model to explain convergences and divergences in the traditional health practitioners and clinical psychologists' conceptualisations for the selected mental health problems. Kühne (2005) defines a model as a description or analogy that is used to visualise something that cannot be directly observed. The development of an explanatory model for this study followed the principles of theory-building by John G. Wacker (1998). Wacker's principles for theory-building are in keeping with the consensus by Hunt (1991), Bunge (1967) and Reynolds (1971) who asserts that the four critical points that make up a good theory include a). its ability to define variables, b). limitation of the domain within which the theory applies, c). the relationship between variables, and, d). future predictions of its applicability.

Wacker's principles have been rated amongst the best through their generality and their ability to predict the future (O'Raghallaigh, Sammon & Murphy, 2010). The researcher opted for these theory-building principles as they were deemed the most applicable in helping the researcher to answer the questions of who, what, where, when, why and how as indicated by Wacker (1998). The researcher aimed at developing an explanatory model that takes into account the views of clinical psychologists and traditional health practitioners about their understanding of the causes, nature and treatment processes of the selected mental health problems.

The following table summarises the principles of theory-building as espoused by Wacker (1998, p. 368):

A general procedure for theory-building and the empirical support for theory

	Purpose of this step	Common question	'Good' theory virtues emphasized
Definitions of variables	Defines who and what are included and what is specifically excluded in the definition.	Who? What?	Uniqueness, conservation
Limiting the domain	Observes and limits the conditions by when (antecedent event) and where the subsequent event are expected to occur.	When? Where?	Generalizability
Relationship (model) building	Logically assembles the reasoning for each relationship for internal consistency.	Why? How?	Parsimony, fecundity, internal consistency, abstractness
Theory predictions and empirical support	Gives specific predictions. Important for setting conditions where a theory predicts. Tests model by criteria to give empirical verification for the theory. The riskiness of the test is an important consideration.	Could the event occur? Should the event occur? Would the event occur?	Empirical tests refutability

Table 01: Wacker's principles of theory-building

- **The definition of variables**

This section entails a clear definition of who and what is included, clearly specifying the exclusions in the definitions. The key questions that this part address is the 'who' and the 'what'. In this section, the present study focused on traditional health practitioners and clinical psychologists. The study specified the mental health problems under investigation, particularly depression and schizophrenia. The conceptualisation of mental illness by the participants and the themes that emerged are about the cases of depression and schizophrenia.

- **Limiting the domain**

This part concerns itself with observing and limiting the conditions by when and where the subsequent similar occurrence is expected. The themes that emerged from the study suggest that it is the views of the traditional health practitioners and clinical psychologists within the specified area of investigation.

- **Relationship (Model) building**

Logically assembles the reasoning for each relationship so that there can be internal consistency. The focus of this step is to address the questions of 'why' and 'how'. In the present study, the themes were clearly explained with the indication of the similarities and differences that emerged from the traditional health practitioners and clinical psychologists' themes.

- **Theory predictions and empirical support**

This involves the ability of this guideline to give predictions for future applicability and the settings for the theory to be tested. This is addressed by the questions of ‘could’, ‘would’ and ‘should’ as far as the applicability of the developed theory is concerned. The findings of the study, as presented in the next chapter, suggests general applicability which may not change over time as far as the themes and subthemes of the clinical psychologists and traditional health practitioners on the selected cases are concerned.

6.9 Quality criteria

- **Trustworthiness**

  This refers to the demonstration that the evidence for the results reported is sound and that the argument made based on the results is strong (LaBanca, 2010). According to Elo, Kääriäinen, Kanste, Pölkki, Utriainen and Kyngäs, (2014), trustworthiness entails the availability of rich, appropriate, and well-saturated data. In the context of the present study, the researcher ensured that the results of the study meet the criterion of trustworthiness by making and keeping the field notes and a reflective journal through the process of the study to evaluate his position in the study and the processes involved. The aim was therefore to minimise factors that may create bias in the research findings. The process of research was outlined in detail, in respect of data collection, sampling, analysis and reporting

- **Conformability**

This refers to the extent to which the results of a study can be confirmed or concurred by other researchers (Baxter & Eyles, 1997). In the context of the present study, the researcher aims to ensure that the results of the study meet the criterion of confirmability through regular discussions with the supervisors about the processes of the study and the research findings to avoid falsified hypotheses and interpretation bias.

- **Transferability**

This refers to the resonance that emerges from a study through its ability and potential to be applicable and valuable across a variety of situations and contexts (Tracy, 2010). In the context of the present study, the researcher will ensure that the results of the study meet the criterion of transferability by providing a highly detailed description of the research situation and methods when reporting.

- **Dependability**

This refers to the stability of the research findings over time (Bitsch, 2005). It also involves the ability of the same research processes that are done separately to yield the same results (Billups, 2014). In the context of this study, the researcher ensured dependability through the code-recode method which entails the coding of the same research data two separate times with a gestation period in between to compare the similarities in the results of the two codes.

6.10 Ethical considerations

- **Permission for the study**

The researcher sought and obtained ethical clearance (certificate number TREC/199/2019: PG) from the relevant university ethics committee before commencing with the study.

- **Informed consent**

To adhere to this important ethical principle, the researcher ensured that the participants give their informed consent before the study could commence (See Appendix 1A: Informed consent letter and form – English version, and Appendix 1B: Informed consent letter and form – Sepedi version). The participant gave informed verbal consent for their willingness to participate before the interviews could commence.

- **Anonymity and confidentiality**

This means that sensitive and personal information provided by participants should not be made available to everyone (Bless, Higson-Smith & Kagee, 2006). For this study, the researcher ensured that the names of participants and other possibly identifying information are not in any way revealed. Secondly, the participants were given pseudo names for purposes of identification.

- **Respect for participants' rights and dignity**

According to Bless, Higson-Smith and Kagee (2006), no research project should in any way violate the human and legal rights of study participants. For the present study, the researcher ensured that the basic principle with relation to participants' rights and dignity was observed without any prejudice or criticism.

6.11 Conclusion

This chapter was aimed at outlining the roadmap which this study followed to achieve the desired outcomes. This chapter presented the methodological, epistemological and ontological issues that were of consideration in shaping this study. The research design was outlined followed by the sampling methods, data collection methods, data analysis steps, quality criteria and ethical issues that were observed during the process of this study. Lastly, the chapter discussed the principles of theory-building by John Wacker. The Thematic Content Analysis that was used through the process of data analysis has yielded significant themes and subthemes which will be discussed in the next chapter.

CHAPTER SEVEN

PRESENTATION OF RESULTS

7.1 Introduction

This chapter will present the demographic characteristics of the participants and the themes and subthemes that emerged from the findings. The emerged themes and subthemes are divided into two parts. The first part illustrates the themes and subthemes from the research protocols of clinical psychologists while the second part will illustrate the themes and subthemes from the traditional health practitioners' protocols. The researcher followed the thematic content analysis steps as espoused by Braun and Clarke (2006), to process the data. The presentations in this chapter are limited to step three (searching of themes), step four (reviewing of themes) and step five (definition and naming of themes). The researcher's focus on these critical steps was a continuation of the first two steps (familiarisation with the data, and generating of initial codes) which were continuously observed during the data collection process to strengthen the quality of the data collected. The chapter is concluded by giving a summary of the findings of the study.

7.2 Demographic characteristics of the participants

As it was indicated in the previous chapter, the sample of this study consisted of 12 participants (06 clinical psychologists and 06 traditional health practitioners). From the sample, there were 08 females and 04 males. There were 04 female psychologists, 02 male psychologists, 04 female traditional health practitioners and 02 male traditional health practitioners (Table 1). The participants' ages ranged from 36 - 52 years for the psychologists and 32 – 82 for the traditional health practitioners. The psychologists were drawn from Polokwane and Lebowakgomo in the Capricorn District Municipality. The traditional health practitioners were drawn from Mamaolo, Seleteng, Mashite, Mogodi and Sekurwaneng Villages of the Lepelle-Nkumpi Local Municipality in Limpopo Province. The clinical psychologists were interviewed in English while all 06 the traditional health practitioners were interviewed in northern Sotho as it is their mother

tongue language. The homogeneity of the traditional health practitioners in this study can be related to the fact that the villages they were drawn from have been predominantly inhabited by this language group in terms of the geopolitical history of South Africa.

Table 02: Demographic Characteristics of the participants

Participant No:	Age	Gender	Language	Occupation
Participant CP1	32	Female	English	Clinical Psychologist
Participant CP2	36	Male	English	Clinical Psychologist
Participant CP3	37	Female	English	Clinical Psychologist
Participant CP4	36	Female	English	Clinical Psychologist
Participant CP5	36	Female	English	Clinical Psychologist
Participant CP6	38	Male	English	Clinical Psychologist
Participant THP7	54	Female	Sepedi	Traditional Health Practitioner
Participant THP8	64	Male	Sepedi	Traditional Health Practitioner
Participant THP9	82	Female	Sepedi	Traditional Health Practitioner
Participant THP10	56	Female	Sepedi	Traditional Health Practitioner
Participant THP11	32	Male	Sepedi	Traditional Health Practitioner
Participant THP12	67	Female	Sepedi	Traditional Health Practitioner

7.3 Emerging themes and subthemes

The following themes from psychologists were identified by the study: a). collateral information as a major determinant in the assessment and treatment of mental illness; b). classifications of mental illness; c). the symptomatology of mental illness; d). causes of mental illness; e). the multidisciplinary approach in the treatment of mental illness; and f). views regarding the collaboration of Clinicians and Traditional Health Practitioners. The table below summarises these themes and subthemes.

Table 03: Emerging themes and subthemes in the case formulations by clinical psychologists

THEMES	SUBTHEMES
Theme 1: Collateral information as a major determinant in the assessment and treatment of mental illness	
Theme 2: Classifications of mental illness	Subtheme 1: Depression as a Mood Disorder Subtheme 2: Schizophrenia as a Psychotic disorder
Theme 3: The symptomatology of mental illness	Subtheme 1: Emotional symptoms of mental illness Subtheme 2: Physical symptoms of mental illness
Theme 4: Causes of mental illness	Subtheme 1: Biological causal factors Subtheme 2: Psychological causal factors Subtheme 3: Social and environmental causal factors
Theme 5: The multidisciplinary approach in the treatment of mental illness	Subtheme 1: Medical interventions Subtheme 2: Pharmacological interventions Subtheme 3: Psychological interventions
Theme 6: Views regarding the collaboration of Clinicians and Traditional Health Practitioners	Subtheme 1: Positive views regarding the collaboration Subtheme 2: Negative views regarding the collaboration

The themes which emerged from the interviews with the traditional health practitioners suggest that a) divination as the main process of enquiry, b) descriptive names of mental illness, c) conceptualisations of stress-related and depressive disorders by Traditional Health Practitioners, d) views on causes of mental illness, e) the effectiveness of the Western approach in the treatment of some forms of mental illness, f) the relationship between religion and African traditional practices; g) a calling as symbolised by symptoms of mental illness, and, h) traditional health practitioners' views on the collaboration between themselves and western health practitioners.

Table 04: Emerging themes and subthemes in case formulations by traditional health practitioners

THEMES	SUBTHEMES
Theme 1: Divination as the main process of enquiry	Subtheme 1: Enquiry about the nature, cause, and other related factors Subtheme 2: Illnesses resulting from mischievous acts Subtheme 3: Intervention to be provided
Theme 2: Descriptive names of mental illness	Subtheme 1: Makgoma (social contamination) Subtheme 2: Kgatelelo ya monagano (Oppression of the mind/stress) Subtheme 3: Go hlakana hlogo (mental confusion) Subtheme 4: Go gafa / Bogaswi (Madness) Subtheme 5: Go swarwa ke badimo (Ancestral possession)

Theme 3: Conceptualisations of stress-related and depressive disorders by Traditional Health Practitioners	
Theme 4: Views on causes of mental illness	Subtheme 1: Stressors Subtheme 2: Witchcraft due to revenge Subtheme 3: Disregard of ancestral calling Subtheme 4: Witchcraft due to jealousy Subtheme 5: Inheritance of illness from the person named after
Theme 5: The effectiveness of the Western approach in the treatment of some forms of mental illness	
Theme 6: The relationship between religion and African traditional practices	
Theme 7: A calling as symbolised by symptoms of mental illness	Subtheme 1: Training to become a healer (go thwasa) Subtheme 2: Opening of prophetic spirit (Go bulwa moya) Subtheme 3: To appease and plead with the ancestors (Go phasa badimo)
Theme 8: Traditional health practitioners' views on the collaboration between themselves and western health practitioners	

PART A: EMERGING THEMES FROM CLINICAL PSYCHOLOGISTS

7.3.1 Theme 1: Collateral information as a major determinant in the assessment and treatment of mental illness

In both the cases of depression and schizophrenia, most participants have reported the seriousness of the need for collateral information. They have shown that little information about the patient hinders their ability to diagnose and manage further, whereas more detailed collateral information assists in their formulation of the condition, the diagnosis as well as the treatment plan. The collateral information is collected from the family of the patient, or anybody who was with the patient at the time they started presenting with the symptoms.

> *"..when you get into psychotherapy to understand exactly what it is that has happened before, it is important to get collateral information from the patient's family or anybody who was with him or her when everything started in order to get more information. Then, you can get to psychotherapy."* (Participant CP1)

> *"..and after the patient has been stabilized, I would be able to interview him. The family would also obviously be needed so that they can give more collateral information."* (Participant CP4)

The extracts that were used suggest that the collateral information is collected through an interview process that is conducted by the therapist.

Some participants have further demonstrated that in CASE B (see appendix 2B) a patient's presentation may be suggestive of multiple diagnoses. They argued that the collateral information can clarify what exactly happened before the symptoms could manifest as well as the duration of those symptoms and other factors involved. As indicated by the extracts below, the results suggest that there are common symptoms that are found in several mental conditions, therefore necessitating the need and the purpose of obtaining collateral information to diagnose and further treatment.

> *"..sometimes without enough information, it may not be easy to get it precisely on what the condition is. Looking at the changes, we don't know for how long he has been through these changes. So, it could be adjustment disorders, it could be mood disorder with psychotic features. I am not sure if the person is using substances as well. It could be a substance induced psychotic disorder since we a not yet clear whether he is using substances or not."* (Participant CP1)

> *"This looks like a Brief Psychotic Disorder on the basis of the available symptoms. However, it could still be anything ranging from this diagnosis to schizophrenia depending on the more information I get from the collateral sources."* (Participant CP6)

The extracts above demonstrate the importance of the collateral information that is critical in the assessment, diagnosis and treatment of mental illness according to the participants.

7.3.2 Theme 2: Classifications of mental illness

The reports from the participants have shown that the two cases of depression and schizophrenia respectively, which were used in this study represented mental health conditions and not medical conditions. They have further shown that these conditions belonged to two different categories of mental illness according to their knowledge of the classification systems which are in use.

Subtheme 1: Depression as a mood disorder

Most participants have viewed the first case (CASE A) of the present study as that of major depressive disorder. They have demonstrated that it belongs to the mood disorders, depressive disorders in the Diagnostic and Statistical Manual of Mental Disorders, fifth edition (DSM 5). The case is deemed that of major depressive disorder because of the symptom picture, as well as the main distinguishing symptoms that differentiate it from the other mood disorders, that of persistent sadness for more than

two weeks. The results further suggest that major depressive disorder has some specifiers which are clarified and determined through the collateral information. This is shown in the extracts below:

> *"She is clearly suffering from Major Depression Disorder. I am not sure of the specifiers because one might need more information pertaining to this case. But it seems like it is not enough to warrant Dysthymia / persistent depression. This is understood to be a mood disorder but considerations of her culture are important before or during her diagnosis."* (Participant CP6)

> *"These are the classical symptoms of depression. If there is now two weeks or more with her presenting with the symptoms she is presenting with, then it is clearly a major depressive disorder and not any other mood disorder. The condition is falling under the mood disorders."* (Participant CP4)

> *"I understand that the patient is not feeling well. Is undergoing some change in emotions or feelings. And this is actually affecting her performance. I am referring to performance in the family, or performance even at work. She sleeps most of the time. These are the symptoms of major depressive disorder. According to my understanding of the DSM 5, I think this condition falls under the depressive disorders. It is a mental illness."* (Participant CP1)

The participants of the study suggested that depression is a mood disorder. They further asserted that it has some specifiers that differentiate it from other mood disorders and that are clarified through the process of collateral interview.

Subtheme 2: Schizophrenia as a psychotic disorder

According to most participants, the second case (CASE B) in this study represented schizophrenia which belongs to the category of the schizophrenia spectrum and other psychotic disorders in the DSM 5. Schizophrenia, according to the participants, is a

psychotic disorder characterised by the loss of touch with reality, delusions, hallucinations, disorganisation of behaviour and other emotional symptoms. This is illustrated in the extracts below.

> *"I understand the case to be that of a psychotic disorder. With the disorganization of behaviour coupled with delusions and hallucinations it is clear that he has somewhat lost touch with reality. I think it is a case of schizophrenia."* (Participant CP3).

> *"Matome seems to be experiencing a range of cognitive, behavioural and emotional dysfunctions. His behaviour is grossly disorganized and he is experiencing symptoms of delusions and hallucinations. Matome is presenting with Schizophrenia first episode in partial remission."* (Participant CP5)

> *"...my understanding of the case is that of a young man presenting with a psychotic disorder. In my view I think I can name the condition schizophrenia because he is presenting with hallucinations. We have both visual and auditory hallucinations. He is presenting with delusions of grandeur. There are also some disorganized symptoms that we find also in schizophrenic patients."* (Participant CP4)

These assertions suggest that the presence of symptoms such as delusions and hallucinations confirms the diagnosis of schizophrenia as a psychotic disorder and distinguishes it from other categories of mental illness.

7.3.3 Theme 3: The symptomatology of a mental illness

The findings of this study seem to suggest that mental illness manifests in several symptoms that can be classified as either physical or emotional symptoms. Based on the two cases under investigation, the results have shown that both depression and schizophrenia may manifest themselves through emotional and behavioural symptoms.

Subtheme 1: Emotional symptoms of mental illness

It appears from the findings of the study that both depression and schizophrenia may manifest through emotional symptoms. These emotional symptoms have much to do with the subjects' feelings as opposed to physical symptoms.

a). Depression: Most participants have shown that depression may present itself in the form of emotional and behavioural symptoms which may range from diminished interest, feelings of hopelessness and helplessness, guilt, agitation, difficulty in concentration to suicidality. The extracts below demonstrate that.

> *"There may sometimes be markedly diminished interest or pleasure in all or almost all activities that one used to enjoy. Sometimes they may present with a inappropriate guilt, diminished ability to think or concentrate and many others."* (Participant CP5)

> *"Yes, sometimes the patient may present with hopelessness, helplessness and feeling guilty."* (Participant CP3)

> "*Sometimes they even present with a diminished ability to think or concentrate, or indecisiveness, nearly every day. These symptoms should not be due to the effect of a substance. They should have affected functioning in at least one area and they should have at least lasted for two weeks."* (Participant CP6).

This finding seems to suggest that the presence of emotional symptoms that range from diminished interest, feelings of hopelessness and helplessness, guilt, agitation, difficulty in concentration to suicidality are a confirmation of the presence of depression.

b). Schizophrenia: Patients with schizophrenia may also present with emotional symptoms which, according to the participants, may include the following, lack of emotional expression and motivation, avolition and catatonia. This is shown in the extracts below.

> *"..sometimes people with schizophrenia may present with a diminished emotional expression or avolition, or they can sometimes become catatonic."* (Participant CP5).

> *"Yes, they can be paranoid and they can lack, you know, emotional expression and lack motivation generally. Those are some of the things they can present with." (Participant CP2).*

> *"Okay. They may present with many symptoms that may range from emotional withdrawal, lack of emotional expression, at times, so much excitement that may not be associated with anything tangible, unprovoked crying spells and so on." (Participant CP1)*

For the participants, an inability to express emotions and lack of motivation, avolition and catatonia is a confirmation of the presence of schizophrenia.

Subtheme 2: Physical symptoms of mental illness

The findings of the study seem to suggest that in addition to emotional symptoms, mental illness may manifest through physical symptoms. This seems to also apply in both depression and schizophrenia as the centre of the investigation in the present study.

a). Depression: Depression may present with physical symptoms that include weight loss or gain, loss of energy, tiredness and psychomotor retardation. These are perceived as the symptoms that can be observed by others, as opposed to subjective reports of the individual having the symptoms. This is shown in the extracts below.

> *"...the other symptoms of depression include significant weight loss or sometimes weight gain, loss of energy, tiredness most of the day."* (Participant CP1)

> *"... a significant weight loss when not dieting or weight gain. At times, it can be a slowing down of thought and a reduction of physical movement as observed by others*." (Participant CP6).

> *"Individuals with schizophrenia, they can lack, you know, emotional expression and lack motivation generally. Those are some of the things they can present with."* (Participant CP2)

One participant has further asserted that depressive symptoms may sometimes co-occur with symptoms of other conditions which may also differ from one patient to another.

> *"Okay, the other symptoms that can be associated with such a condition; you can also have your anxiety symptoms as well as your psychotic symptoms which appear with the condition."* (Participant CP4)

This assertion suggests that there is a possibility of coexistence of depression and other types of mental illness with some patients.

b). Schizophrenia: Individuals with schizophrenia, on the other hand, may present with physical symptoms that include paranoia, social withdrawal, speech and behaviour disorganisation, aggression towards people and property, and hallucinations. This is shown by the following extracts.

> *"The other symptoms that we can find include some disorganized speech and disorganized behaviour. You can also find aggression with such people where they can be violent towards others and destruct property."* (Participant CP4)

> *"You may at times find a disorganized speech such as a frequent derailment or incoherence, catatonic behaviour or even visual hallucinations."* (Participant CP6).

> *"At other times, they may present with aggression towards people, animals or property, collection of garbage, the neglect of their personal hygiene and the tidiness of their environment, roaming around, talking to self, high levels of energy, eating nonsense and*

so on. They often present with many symptoms and the symptoms may differ from one individual to another." (Participant CP1).

The information shared above seems to suggest that both depression and schizophrenia may be manifested in both emotional and physical symptoms. The symptoms may also differ from one individual to another.

7.3.4 Theme 4: Causes of mental illness

The results of this study have shown that many causal factors are responsible for mental illness leading to depression and schizophrenia. These causal factors are in the form of biological, psychological and social factors, either in isolation or in combination. The biological causes are associated with the instability of the biological chemical elements within the body. The psychological causes are presented as the unstable psychological processes within an individual's mind. Lastly, the social causal factors are presented as the external social and environmental factors that may lead to mental illness. The outcomes further suggest that the factors that are attributable to the causes of mental illness, in the context of the two cases under investigation, are in line with the western approaches to the aetiology of mental illness.

Subtheme 1: Biological causal factors

The outcomes of the study have shown that biological factors such as chemical imbalances and underlying medical conditions like thyroid problems, as well as hereditary and genetic factors, are responsible for mental illness.

a). Chemical imbalances: The results of the study have shown that a human body is made up of biological chemicals that are responsible for all the processes that take place within the body. These chemicals may be in the form of hormones and neurotransmitters that facilitate the way we feel and the way we think. The imbalance in these chemicals is responsible for the malfunctioning of the body and the mind. This is demonstrated in the extracts below.

> *"...from biological causes where you find that there is a chemical imbalance, such imbalance of neurotransmitters like dopamine and serotonin, the person can be prone or vulnerable to being depressed. You know, biochemical imbalance where there is a high concentration of dopamine, a person can be exposed to schizophrenia."* (Participant CP2)

> "*The causes of Schizophrenia are quite variable, and sometimes there is no direct cause but it is accepted that the cause is a combination of genetics, environmental factors and altered brain chemistry that might be contributing to the development of the condition." (Participant CP5).*

The presence of mental illness in the form of depression and schizophrenia is viewed by the participants as suggestive of the imbalance of chemicals in the brain.

b). Underlying medical conditions: The results of the study seem to suggest that at certain times, other medical conditions may result in mental illness. Conditions like HIV have been shown to affect the brain cell makeup and function, at times, leading to the causation of mental illness due to altered brain cell formation and function.

> *"It may be caused by other medical conditions such as HIV. HIV alters one's makeup of the brain cells and how they should function. An alteration in their formation and function may cause mental illness."* (Participant CP6)

> *"..medical conditions such as HIV.., HIV has been found to be accountable for the causation of mental illness like schizophrenia among others." (Participant CP4)*

It does appear that in some instances, depression and schizophrenia may be caused by the presence of other medical conditions such as HIV due to its alteration of brain formation and mental processes.

c). Hereditary and genetic factors: The results of the study have shown that there are conditions that may be passed on from one generation to another. These conditions may be inherited from one parent through the blood, genes and chromosome makeup and may be passed on to the children. Mental illness is viewed as a condition that may be passed from generation to generation through the same process. The extracts below demonstrate this assertion.

> *"Schizophrenia can be explained by biological factors such as hereditary and genetic explanations. It can be passed through the genes, hormones and chromosomes from one generation to another. Again, Matome's medical history is not known as of yet. With that in mind, there could be other medical conditions that could lead him into psychosis. There could be quite many explanations to the causation of schizophrenia; hence a comprehensive history taking is very important."* (Participant CP3)

> *"There are many other factors that may be responsible for such a condition. Sometimes schizophrenia can be passed through genetic and hereditary factors from a parent to the child through blood."* (Participant CP6)

The participants understand mental illness in some instances to have been inherited from parents through the blood in individuals with depression and schizophrenia.

Subtheme 2: Psychological causal factors

The outcomes of the study show that there are psychological factors that are responsible for the causation of mental illness. These factors include an individual's personality makeup that makes them prone to mental illness, poor coping skills when faced with difficulties, pessimistic views of self and the world, traumatic life experiences, cognitive distortions in the form of automatic negative thoughts and underlying unexpressed difficulties. The extracts below demonstrate these findings.

> *"In my view, depression is often caused by cognitive distortions or negative thoughts regarding the challenges that one is faced with. That is why you may find two people going through the same experience but being affected differently based on how they conceptualize the problem."* (Participant CP3)

> *"There may also be psychological issues such as a person's personality, a person's poor coping skills, a person's inability to accept themselves, and you know, a person's negative thoughts that they have about themselves."* (Participant CP2)

For the participants, some individual's personalities are made up in a way that makes them prone to the development of mental illness. Traumatic experiences and one's inability to face difficulties as well as one's way of thinking and interpreting events around them are understood by the participants to account for the causation of mental illness such as depression and schizophrenia.

Subtheme 3: Social and environmental causal factors

The participants of the study have reported that there are social factors that may predispose a person to mental illness. These factors may include one's inability to deal with the death of a loved one, the loss of a relationship, loss of employment, or work-related stressors, financial stressors, marital problems, recreational substances, peer pressure and poverty. These assertions are depicted by the extracts below.

> *"Depression is caused by a lot of factors. In this situation, it might be work-related pressure, unfulfilling education, cognitive distortions-negative thought. Stress such as a sudden death of a loved one, loss of relationship, loss of employment, marital problems or many other factors may be responsible for such a condition (schizophrenia)."* (Participant CP6)

> *"..social factors including poor coping skills, a trauma, relationship conflicts, financial troubles or other stressful life events."* (Participant CP5)

> *"..there can be some issues which Matome might have gone through such as the experimentation with substances given the fact that you said that he has just been in Gauteng for less than a year, probably his first experience from his parents' supervision and his first taste of independence."* (Participants CP3)

For the participants, the above examples are viewed as the external social and environmental factors that account for the causation of mental illness.

7.3.5 Theme 5: The multidisciplinary approach in the treatment of mental illness

The results of this study suggest that the management of mental illness in the form of depression and schizophrenia is a joint effort of a multidisciplinary team. Doctors, pharmacists and clinical psychologists have a role to play which is determined by the severity of symptoms and the level of treatment. The participants in this study further report that psychological intervention commences right at the beginning if the symptoms are less severe, while it is delayed, if the symptoms are more severe in the case of depression. In patients with schizophrenia, the psychological intervention begins after the patient has been stabilised, and does not present with psychotic symptoms anymore. Most of the participants have shown that before or after their assessment, the patients are referred to the doctor for further assessment and the prescription of medication; antidepressants and antipsychotics which are dispensed by the pharmacist. As the symptoms minimise, then the psychologist intervenes further. These findings are demonstrated by the following extracts.

> *"Usually, depression and schizophrenia needs a multidisciplinary team. After diagnosing, we would try to stabilize the mood. And usually we need pharmacotherapy where we would need the*

Doctor to prescribe and the Pharmacist to dispense." (Participant CP1)

"Depression is mostly treated pharmacologically and also psychotherapeutically. Schizophrenia also, is mainly treated biologically and also by other means. Meaning, psychotherapeutically and involving other disciplines. Let me say it usually involves the roles of a multidisciplinary team." (Participant CP2)

The participants have indicated that during the process of treatment of depression and schizophrenia, the severity of symptoms as well as the risk assessment determines where the patient should be placed during the process. They have further reported that in the event of severe symptoms and the element of suicidality in depression as well as the level of psychosis in schizophrenia, the patient is treated as an inpatient on admission within a mental health institution. When the symptoms stabilise, and the level of suicide risk is minimal, the patient will be discharged and be treated from home, on given appointments as an outpatient.

"Usually, my intervention also involves risk assessment. After my suicide risk assessment, if I find that the patient is of a high risk, I would admit and treat as an inpatient. If the patient is of a low risk, I would treat her as an outpatient." (Participant CP3).

"Well, we are able to see the patient as an inpatient or an outpatient. As an outpatient we would love to assess whether the person isn't a danger to themselves or to society. Then we would have to hospitalize depending on the SADPERSONS scale demands and requirements. But if we see that the person can be seen from home as an outpatient, you know, we are also able to do that." (Participant CP2)

> *"..with depression, depending on the risk assessment, the patient might be kept as an inpatient if suicide risk is high, or patient would be treated as an outpatient with the support of family members in the event of a low risk and the mental status of the patient. In the case of schizophrenia, during my interaction with him, the patient will be hospitalized until he is stable and is fit and appropriate for leave of absence and ability to continue treatment as an outpatient."* (Participant CP5)

These assertions suggest that the severity of symptoms in patients with depression as well as the presence of psychotic symptoms in patients with schizophrenia leads to a delay in psychological intervention. They further show that doctors and pharmacists have a bigger role in the management of depressive and schizophrenia patients presenting with severe symptoms as compared to psychologists.

Subtheme 1: Medical interventions

The participants in this study have reported that after the assessment by the psychologist is done, they usually refer the patients with severe symptoms of depression and schizophrenia to the doctor before their intervention. The referral is done for further medical assessments to rule out underlying medical conditions and blood toxicology, as well as to put these patients on antidepressants and antipsychotics to stabilise them. These findings are shown in the extracts that are presented below.

> *"Firstly I would refer for a blood test and assessment and management of any underlying medical conditions."* (Participant CP5)

> *"..then I would also refer the patient to the doctor for a medical workup because like I said that it can be caused by a general medical condition like your thyroid problems,.."* (Participant CP4)

> *"Firstly I would have him referred to a doctor for further assessment, intervention and consideration of medication to be stable."* (Participant CP6)

> "*During admission, because we don't know whether there is any use of substances, there could be some toxicology tests done to find out whether there are some toxins in the blood. Then they treat these psychotic features with the antipsychotics."* (Participant CP1)

These seem to suggest that the doctors have a bigger role to play in the first stages of treatment of patients with depression and schizophrenia to rule out the presence of other medical conditions and toxins in the blood before the psychological intervention can be commenced.

Subtheme 2: Pharmacological interventions

According to most participants, after the medical assessments have been completed, the patients are referred to the pharmacists with the antipsychotic and antidepressant prescriptions from the doctor for the pharmacists to dispense. After receiving these medications, due to the severity of symptoms and risk assessment, they can then be treated as either in- or outpatients. Patients with less severe symptoms and less potential risk can be treated as outpatients while those with severe symptoms in the case of depression and severe psychotic symptoms in the case of schizophrenia are admitted and treated as outpatients. The following extracts are an illustration of this:

> *"Depression is mostly treated pharmacologically and also psychotherapeutically. Yes. Someone will be subjected to medication first of all to stabilize their mood. Then when their mood is stable, we are able to provide them with psychotherapy."* (Participant CP2)

> "*If unstable and with severe psychotic symptoms, he will be admitted in a psychiatric ward. If stable, he will be treated on appointment as an outpatient on medication*." (Participant CP6)

The above statements show that severe symptoms are a risk factor for the patient to be managed from home. It further necessitates the admission of the patient to a psychiatric facility in the case of schizophrenia. Severe symptoms in the case of depression warrant the prescription of medication for the patient to stabilise before psychotherapy can commence.

Subtheme 3: Psychological interventions

The findings of this study have shown that psychological intervention which proceeds when the patients have been stabilised commences after the psychologists' interview with the patients and their collateral sources. The intervention is reportedly dependent on the amount of information gathered through the interviews that aim to understand the events that preceded the illness. The extracts that are presented below demonstrate this assertion:

> *"I will conduct a full clinical interview and conduct a risk assessment and based on my assessment I would determine if a referral to a psychiatrist is needed and what type of therapeutic intervention will be done with the patient."* (Participant CP5)

> *"Firstly, with any mental illness, I would like to have the collateral information from the family to help me understand better, when the problems started, if there were any triggers, any stressors so to say. So, I would interview the family members and then I would interview the client in order to make my own diagnosis and come to the conclusion about my clinical impressions."* (Participant CP4)

What is indicated above is that the choice of the mode for treatment and the psychological formulations is dependent on the in-depth information that is gathered through the interview process. The information about the possible triggers guides the process of intervention for psychologists.

The results have further shown that the psychologists' mode of intervention is dependent on the theoretical orientations from which they formulate and draw their

techniques. Some have shown that they often formulate from the psychodynamic approach, Gestalt approach and Cognitive Behavioural approach from which they draw their different intervention techniques. Most participants' interventions are aimed at instilling insight, teaching coping skills, identifying, testing and replacing automatic negative maladaptive thoughts, teaching social and problem-solving skills, supportive therapy and stress management techniques. The extracts presented below demonstrate this assertion:

> *"...mostly we use cognitive therapy where we try to help the patient to correct whatever distortion or negative thoughts that might be going on or she may be going through, so that she can begin to see life in a different way."* (Participant CP1)

> *"I have used a variety of therapeutic techniques based on the root cause of the depression including CBT to address negative cognitions, family-focused therapy to address family relationship conflict as well as various other therapeutic modalities. With schizophrenia, after the patient has been stabilized and he is no longer psychotic I will assist with supportive counselling, coping skills as well as stress management techniques."* (Participant CP5)

> *"Well, our intervention would still be based on your theories. You can employ your insight-oriented psychotherapy which is based on instilling some insight into this person, teach them some coping skills, and teach them how to prevent relapse as well as the social skills. They will also need some problem-solving skills so that they can be functional while living with that kind of illness."* (Participant CP2)

> *"With depression I would test automatic negative thoughts of the patient, identifying maladaptive assumptions, testing the validity of the maladaptive assumptions and eliciting these automatic thoughts. I would also do psycho-education on coping*

mechanisms. Even with schizophrenia, all is dependent on the patient's main challenges, their needs as well as the most suitable methods that can address those needs and help them recover." (Participant CP3)

As can be seen from the above extracts, there are many treatment modalities and techniques according to psychologists. These all depend on how the practitioner understands the presenting problem and the causes of those presenting problems.

7.3.6 Theme 6: Views regarding the collaboration of clinicians and traditional health practitioners

Subtheme 1: Positive views regarding the collaboration

The results have suggested that bringing together the Western health system and the African traditional health system can yield positive results. The participants have reported that it will help in promoting patients autonomy, allowing the two systems to complement each other, and incorporate the spiritual element of human beings which may be well catered for in the African traditional health practice as shown by the following extracts:

"This is a tough one. But, looking at our people, you know, our people have a different way of life. We cannot rule out the issue of cultural or traditional issues. Even if we do, they must still go on with their beliefs, you know, their treatment with their traditional healers or their religious system. Isn't it that the patient is the one who finally decide what they want finally?" (Participant CP1)

"Well, I think it is a very good idea. I have already spoken about the biopsychosocial perspective, and I have realized that the perspective has been missing an element, that is the spiritual element. There are authors who are currently coming up with what is called the extended biopsychosocial model which then encompasses the spiritual element of our patients. That is, if we

treat these patients from the three domains, we might miss out on the spiritual domain which may be a major contributing factor on how people interpret what they are going through." (Participant CP2)

"I think if this is well managed, it will be a way of these two systems complementing each other and catering for the best health needs of the patients with the patients' beliefs, needs and autonomy in mind." (Participant CP3)

Some of the participants went further to suggest that the idea of collaboration will create space for the clarification of the misconceptions about how either of these systems practice, enhancing a holistic approach to patient management. The participants further report that the collaboration will create an opportunity for either of the systems to learn how the other system operates as illustrated in the extracts below:

"..the two systems can be oriented to how each of them practices so that it nullifies the misconceptions that already exist, especially about the African health system. (Participant CP3)

"There is a need to educate both sides on the scope of each. It will direct practitioners of who and when to refer to whom and for what." (Participant CP6)

"..if they bring them under one umbrella, one group will have the opportunity to learn how one group does their things vice versa." (Participant CP1).

"I think collaboration is a good thing because it enhances the element of a holistic approach and the making of proper diagnosis with no doubts and flaws." (Participant CP2)

One participant has indicated the need for the formulation of legislative frameworks and models that will facilitate the process of collaboration with particular reference to the location of practice and the referral processes.

> *"The only challenge is the model of collaboration; how the collaboration has to go about. Are we then saying all those traditionalists and spiritual pastors have to come to the hospital or they can treat where they are where we have a link with them, further sending them the patients who require their intervention? Another question is if they have to be part of the MDT (multidisciplinary team)."* (Participant CP2)

Another participant has reported about the need to have specialised institutions for the traditional health practitioners on the notion that, putting them in hospitals may infringe on other people's rights regarding their beliefs.

> *"..it might be difficult for them (THPs) to practice in hospitals since not everybody believes in traditional practices. Remember there are Christians who may not believe in such practices, which might be affecting them negatively. I think if there was to be a place where they practice from, like an institution for them, where we would refer patients to if there is a need and without imposing on patients, it might be better."* (Participant CP3)

There seems to be a suggestion that a well-coordinated collaboration, with well-developed practice models and referral procedures, will create more opportunities for learning between the two health systems and further provide a holistic approach in the management of mental illness with particular incorporation of spiritual factors that are in play. It will further provide an opportunity for both systems to complement each other's shortfalls to the benefit of their service recipients.

Subtheme 2: Negative views regarding the collaboration

One participant has expressed some concerns about the collaboration of the western and African traditional healing systems based on unscientific training of traditional health practitioners, lack of legislative frameworks for the governance of the collaboration as well as different conceptual orientations. She views these factors as detrimental hindrances to the process of collaboration of the two systems as illustrated in the extract below:

> *"..as psychologists, we went to school, we studied psychology and are of the notion that psychology is a science. Even though they also receive training, their training is not a science. So, I don't see how I personally can collaborate with them. I actually do not see it as a possibility. To start with, if I had to refer to them, what policy would be guiding that referral? What frame of work, frame of reference or theoretical perspective would I be acting from? We are using an art, a science, and the way we view the causes of conditions is quite different. I can give an example of the fact that, with most of the traditional practitioners, when patients with such conditions go to them, they often attribute the causes to witchcraft. With us, it is completely different. We have theories that can help us to attribute causes."* (Participant CP4)

This seems to suggest that the absence of legislative frameworks that govern the processes of referral, training and practice works against the possibility of the collaboration of the western and African traditional health systems.

PART B: EMERGING THEMES FROM TRADITIONAL HEALTH PRACTITIONERS

7.3.7 Theme 1: Divination as the main process of inquiry

The results of this study revealed the significance of divination as the main form of enquiry during a consultation with traditional health practitioners. All the participants have emphasized the importance of the throwing of divination bones (go t*šholla* ditaola) as the entry point during their interaction with their clients. The results further explain

some reasons associated with the need for divination before any intervention can be provided. These reasons include a) seeking clarity about the nature, cause, and other related factors of the main complaint, b) avoidance of attempting to treat conditions that may have resulted from the ill person's mischievous acts, which may, in turn, affect the healer, and c) seeking direction regarding the treatment procedures to be followed and the items to be used. These are further discussed in the following subthemes.

Subtheme 1: Enquiry about the nature, cause, and other related factors

The participants have shown the importance of divination as a method through which they can be guided about the nature of the problem that is being presented, the causes as well as all the factors that may be involved in the presentation at hand. The divination bones can provide guidance taking into cognisance the individual differences. This assertion is supported by the extracts below:

> *"There is no way you can understand a person without knowing the types of problems he is coming with. You will need to consult your bones first."* (Participant THP9)

> *"There is nothing more important than being guided by the divination bones because conditions are different, people are different, and what they want is different. If you cannot make it a point that you are guided by the bones, you will get into trouble."* (Participant THP8).

Divination has been deemed by the healers as an important tool that helps them to understand the causes of an illness that is presented to them. It complements the information that is provided to them about understanding the illness as understood by the collateral sources.

Subtheme 2: Illnesses resulting from mischievous acts

The results of the study have further shown that there are instances where people fall ill as a result of having committed mischievous acts. These acts are said to include

bewitching other people or killing other people. The process of divination guides the healer about the causes of the illness that is presented. They further guide the healer about whether to intervene or not and the reasons thereof. If the healer provides intervention in cases where the illness was caused by the commission of mischievous acts, they will relieve the person's suffering from the illness and inherit it themselves. This is illustrated in the extracts below:

> *"In some instances, they would have bewitched people. He has killed a person, and you are releasing/relieving him (go mo swarolla), then I help her but whatever that is troubling her then come back to me."* (Participant THP8)

> *"We are guided by the divination bones. We are assisted by consulting them first. We are afraid of the fact that I can just jump straight to treating her while she has a problem herself. Then that problem passes on to me."* (Participant THP9)

The above information seems to suggest that divination is an important tool that is used by traditional health practitioners to avoid treating conditions that may be incurred from their service seekers through their mischievous acts.

Subtheme 3: Intervention to be provided

The results have shown that it is through the process of divination that they can understand whether or not to provide intervention, as well as the type of intervention to be provided. The divination bones can provide answers to all the questions they may have before intervention can be provided. In the case where medicines have to be prepared, the divination bones can guide the types of medicines to be given. This is illustrated in the extracts below.

> *"..once I throw the divination bones, they will tell me everything. They will tell me that this person is suffering from this illness. I will then ask the bones again, whether to provide the medicines or not. They will tell me to provide. If they deny that we should not provide*

the medicine, nothing we can do because they have the tendency of denying. We will then ask them the reasons for not providing. They will tell us that we should not provide because of this and that." (Participant THP10)

This seems to suggest that divination is the critical tool that informs the healers about the guidance in the process of intervention.

7.3.8 Theme 2: Descriptive names of mental illness

This study has shown that some of the mental illness types are better described than defined. Most of the mental health conditions that are treated by traditional health practitioners are understood by them in a descriptive form more than a definitive form. Most participants have reported about the types of mental illness which were presented in descriptive names as discussed below.

Subtheme 1: Makgoma (social contamination)

One participant has reported a condition called Makgoma (social contamination) which may affect a person as a result of the death of a significant relative after which they don't get cleansed. Sometimes this condition results from sleeping with a widow or widower who is not cleansed after losing their partner. This condition may reportedly present itself with the typical symptoms of mental illness as presented in the first case study (see appendix 2A). This is illustrated by the extract presented below:

"There is one illness called social contamination or social pollution (is a kind of illness that normally caused when spouse, children, relatives died and you are not cleansed at all or even not properly cleansed. Or sometimes you sleep with a woman who has just lost her partner and she is not cleansed). Sometimes it hides itself. You then go to medical doctors, where they will not realise anything. They check you, and prescribe pills for you, and those pills will not assist you." (Participant THP12)

In the view of the results of this study, the condition that presents itself as what may be understood by clinical psychologists as depression is understood as “makgoma” by traditional health practitioners.

Subtheme 2: Kgatelelo ya monagano (Oppression of the mind/stress)

The symptoms similar to those reported in Case Study A which is understood as depression by clinical psychologists were reported by the participants to be those of the “oppression of the mind” (stress) (kgatelelo ya monagano). This is understood as a condition that suggests that the individual presenting with it is not well mentally and requires intervention. The illustrations presented below illustrate this assertion.

> *“...when she thinks too much, the brain gets tired. When your brain gets tired, your soul also gets tired. Even thinking too much also damages the body. Then if it damages the body, it also damages the heart, and then we see her heart hurting, leading to her thoughts of taking her life. What she is going through can be associated with thinking too much. She has an oppression of the mind (stress) (kgatelelo ya monagano).* (Participant THP11)

> *“...when she comes to us, you will find that we say it is “stress”. And when she is like that, we take her to hospital. When a person has stress, they want to be put well at the hospital (rearranged)”* (Participant THP8)

The symptoms associated with the presentation in the case study seem to suggest that the person experiencing them is under stress. Stress is understood by traditional health practitioners as a condition that leads to tiredness of the mind, body and heart, which may, in turn, lead to an individual thinking of taking their own life. The results further suggest that the stress is well managed at the hospital through western forms of treatment.

Subtheme 3: Go hlakana hlogo (mental confusion)

This study has revealed that at times, symptoms similar to those illustrated in Case Study B are understood as mental confusion (go hlakana hlogo) from the perspective of the traditional health practitioners. This presentation is further understood as a condition that usually results from ignorance of communication from the ancestors that leads to mental confusion. This is illustrated in the extract below.

> *"It is not mental illness or anything. It is that of the "ancestors". He did not pay attention to it until the point where he got mentally confused (go hlakana hlogo). Then it will end up as if it is mental illness while it was not actually mental illness."* (Participant THP8)

Symptoms suggestive of mental confusion are understood by traditional health practitioners as a sign of ignorance of communication from the ancestors and presents themselves in what may look like mental illness while it is not a mental illness.

Subtheme 4: Go gafa / Bogaswi (Madness)

it was suggested by the results of this study that the presentation of symptoms that were illustrated in Case Study B (see appendix 2B) and others which may range from roaming around, poor hygiene, aggression towards people, animals and property and talking and laughing to self is an indication of madness (bogaswi).

> *"If a person complains, he or she has illness in the body. Firstly, she will have high blood. She will neglect personal hygiene, be aggressive towards people, animals and property, talk and laugh alone, and roam around. Afterwards, she will have stress which will lead to madness (bogaswi)."* (Participant THP10)

The presentation of a person who roams around, neglects their hygiene, talks and laughs to themself, and becomes aggressive towards people and property is understood by traditional health practitioners as madness, which is a form of mental illness.

Subtheme 5: Go swarwa ke badimo (Ancestral possession)

The results of this study have shown that at times, individuals may present with symptoms similar to those of mental illness, which occur as a result of an individual being possessed by ancestral spirits. The possession may present as a need for the symptomatic person to become a healer. However, the results have further uncovered that even though the presentation may be similar to that of a person with mental illness, ancestral possession is a curable illness. This assertion is illustrated by the extract below:

> *"When we look at it, especially the symptoms, we may just say that Mologadi has an "ancestral possession/ancestral calling" (go swarwa ke badimo / pitšo ya badimo). When you are sick like the way in which Mologadi is sick, we just say you are possessed by ancestors. Your healing will come when we help you through the process towards becoming a healer. That's how you will get cured."* (Participant THP7)

What the results seem to suggest is that there is a similarity between the symptoms of mental illness and the symptoms suggesting ancestral possession. The symptoms of mental illness are treated while the symptoms of ancestral possession disappear after the initiation process of one to become a healer.

7.3.9 Theme 3: Conceptualisations of stress-related and depressive disorders by traditional health practitioners

The results of this study have shown that symptoms such as lack of sleep, hopelessness and helplessness, loss of appetite, social withdrawal and suicidal ideations that are depicted in the first case are perceived by traditional health practitioners as associated with stress-related and depressive conditions. This argument depicts the similarities between the clinical psychologists and traditional health practitioners' conceptualisation of mental illness, particularly depression even though it is named differently. Clinical psychologists see it as depression while most traditional health practitioners refer to it as stress and some refer to it similar to psychologists. This argument is illustrated by the extracts that are presented below:

"Yes. Let me put it to you like this. I may be troubled by my husband, taking me up and down until I have stress. If he does not change, it may no longer be stress, but change to become depression. That is the reason why a person with depression is said to be having mental illness." (Participant THP7)

"You know, thinking too much? By the way, "stress" can make you confused. The stress due to the separation with her husband, that makes her tired, stressed and a different person." (Participant THP12)

"...when she comes to us, you will find that we say it is "stress". And when she is like that, we take her to the hospital." (Participant THP7).

These outcomes endorse the fact that the condition of stress is both recognised by traditional health practitioners and western practitioners alike. It further indicates that western-oriented health practices are deemed by traditional health practitioners as the most relevant in the management of stress.

7.3.10 Theme 4: Views on causes of mental illness

This study has revealed that many causal factors are associated with mental illness in the view of traditional health practitioners. These factors include stressors, witchcraft due to revenge, disregard of an ancestral calling, witchcraft due to jealousy and inheritance of illness from the person named after. These factors are discussed further below.

Subtheme 1: Stressors

This study has uncovered that the symptoms similar to those in Case Study A are similar to those that result from stressors. The stressors that were reported may include the loss of a significant other on whom one may have depended. Mental illness is also

understood as a condition that may also arise from separation in the form of divorce as shown in the extracts below:

> *"Sometimes you may have a child within your household. Then you will find that this child is the one who assist you in many ways. Is the one who works within the household? Then, the child dies. When the child dies, there is no one who will assist you in the household. Then, you will start complaining, that if the child was still alive in this family, the child will be assisting with this and that."* (Participant THP10)

> *"When your brain gets tired, your soul also gets tired. Now, Mologadi's situation may be caused by thinking too much, because of a "divorce".* (Participant THP11)

This serves to suggest that there are similarities in the conceptualisation of stress by traditional health practitioners and clinical psychologists alike.

Subtheme 2: Witchcraft due to revenge

Some of the participants have shown that the causations of mental illness may be as a result of revenge in the form of bewitchment due to the ill person's evil-doing. The person may fall ill as a result of revenge from the person he or she has bewitched. When the bewitched person seeks help, they return a curse in the form of mental illness. The person who is cursed with mental illness then presents with symptoms similar to those of mental illness. At times, the curse may be placed on an individual for having stolen another person's belongings such as cattle or goods from the house. This is demonstrated in the extracts below.

> *"You may find that even Matome has stolen something from other people. Then, those people will do the way they know. If now you can steal all the herd of the cattle of someone, he will not leave you alone. He will try his best to do something wrong to you, in order to know who stole from him."* (Participant THP10)

"Now, when they steal those people's things, when a person comes to you and say; here is a person who is stealing from me, what must I do to him? I am crying. A person took my phone. When I try to talk to him, he does not want to understand me. He broke into my house when I was not there. I don't know who it is maybe. Sometimes he may bewitch me. Then, what do we do with him, we work on him." (Participant THP9)

What is suggested above is that at times mental illness may be caused by bewitchment as a result of the perpetrator having stolen from the victim or bewitched the victim first. Mental illness may therefore result from a curse that is placed as punishment on a person for wrongdoing.

Subtheme 3: Disregarding the ancestral calling

The participants of this study have reported that at times people present with symptoms similar to those of mental illness as a result of communication from the ancestors which they may disregard. That may include a calling to become a healer or a religious prophet as they may have been when they were still alive. When a person receives a calling from their ancestors to become a traditional healer or prophet, they often develop some health-related issues. When they go to seek help, the healers explain everything to them if it has anything to do with ancestral calling. When they disregard or ignore such a calling, they often fall ill, at times presenting with symptoms similar to those of mental illness. In such cases, they get relieved through being initiated into become traditional health practitioners or prophets. The extracts presented below illustrate this assertion.

"Ancestors sometimes we do not pay much attention to them. Now, only to find that Matome is being troubled by his grandfather who was a member of an apostolic church who wants Matome to become a member of apostolic church. Then, you may find that his father does not care of taking him to other Apostle Prophets for medication so that he will start working in the way his grandfather

was doing. So, if he does not get such assistance that is why he will do what he is doing now." (Participant THP10)

"When Mologadi is the way she is, being possessed by ancestors, when those people wake up, coming to you in spirit, they talk to you and if you don't listen to them, they may cause you an illness in your body or mind. For you to be healed, you have to be initiated to carry out the duties they want you to carry." (Participant THP7)

These assertions seem to suggest that symptoms of mental illness may result from ones' ignorance of the communication from the ancestors about the duties they want one to perform. The management of such symptoms follows the process of initiation into becoming a healer or prophet depending on what the ancestors want.

Subtheme 4: Witchcraft due to jealousy

As shown by the results of this study, people may at times present with symptoms that are suggestive of mental illness as a result of being bewitched due to jealousy. The jealousy may be caused by the realisation of one's ability to provide for their families. Such jealousy may come from neighbours as they realise that one is working and able to provide for his or her family. That is reportedly done to spite his or her parents. This assertion is supported by the extracts that follow.

"We are so jealous. Sometimes you may find that he is working and assisting his mother. How possible can he assist that orphan? Then, we bewitch him so that his mother must not succeed. Then his duties will be to chop off twigs of these trees or to beat the trees with fists." (Participant THP10)

"You may find that sometimes a furniture car can stop right at the home. Then, the neighbour becomes angry; asking so many questions such as how does this child succeed in bringing a furniture car at the home." (Participant THP12)

This assertion strongly associates symptoms of mental illness with bewitchment as a result of jealousy. This is done to spite the ill person's parents as well as to destroy their future.

Subtheme 5: Inheritance of illness from the person named after

One participant has shown that the symptoms of mental illness may at times result from inheriting everything from the person you are named after, especially if they had a mental illness. If one is named after a person who had a mental illness, especially if he or she is deceased, they may later present with symptoms similar to those that the person they are named after had. The extract presented below supports this assertion.

> *"...at times we ask the grandfather to leave Matome alone because we do not deny the fact that Matome is renamed after him. So, please do not want him to do the same things as you were doing."* (Participant THP10)

This suggests that a person may inherit everything from the person they are named after, including symptoms of mental illness. This happens more often when the first bearer of the name is deceased.

7.3.11 Theme 5: The effectiveness of the western approach in the treatment of some forms of mental illness

Some participants have demonstrated their limitations in the management of other types of mental illnesses, particularly stress-related and depressive disorders. The results have further shown that such conditions may cause other physical illnesses which they can manage. Stress-related disorders may cause persistent worry and hypertension which they can manage once the patient has been stabilised at the hospital. They said that they do a referral to the hospital for the management of stress-related and depressive conditions while they are only able to manage physical symptoms that are associated with such conditions. They often administer medicines that assist in elevating the mood and settling other negative emotions related to the disorders as well

as helping the patient to forget about their main worries. This assertion is demonstrated in the extracts that follow.

> *"When she comes to us, you will find that we say it is "stress". And when she is like that, we take her to the hospital. That is the reason we send them to the hospital because their condition needs the services of the hospital. If that person does not go to the hospital, then they come back to me, then I will take her to the hospital myself."* (Participant THP8)

> *"...with conditions such as Mologadi's, we will not be able to help. They want her to go for "counselling". She will sit down and explain everything that is happening to her so that she can be helped. Now with us, things like "counselling" we are not able to do. She will come back to explain to me that she is back from where I sent her for counselling. From there we will consult the divination bones to find out if there are things that are remaining, which we can help her with."* (Participant THP11)

> *"..after she is no longer having stress, we are to check if she does not have any other diseases. If one complains, they can say that person has other diseases such as high blood, stress and others. Then, after she is no longer complaining, we will assist her with other illness on her body. In that case, we will be trying to get rid of other illness on his body."* (Participant THP10)

> *"When she comes to me, I am going to start by preparing oral medicines for her. After that I steam her in order to calm her down. (go iša matswalo a gagwe fase)."* (Participant THP12)

These results put forth the assertion that stress-related and depressive conditions are likely to be accompanied by other physical ailments. According to traditional health practitioners, stress-related and depressive conditions are best managed in a hospital

setting while they can manage the other physical ailments that accompany them. Their treatment commences after the patients have been stabilised in the hospital first.

7.3.12 Theme 6: The relationship between religion and african traditional practices

The findings of this study have dismissed the common notion that nullifies the relationship between Christianity and African traditional practices. The findings suggest that there is a positive working relationship between the two ideological practices which complement one another. They suggest that traditional health practitioners acknowledge the existence of God, go to church, and others even incorporate prayer in their interaction and treatment of their patients. This is supported by the extracts below.

> *"If God has given you power, He has given you. Even when you are asleep, you may find that the ancestral spirit comes and talks to you. When you wake up, you find that there is no one. You have to kneel down and pray. When treating Matome, sometimes while I am seated here, the ancestors can instruct me to follow a certain instruction, and give certain medicines to Matome so that he should eat or drink it. I can even be instructed to take a candle and put it upright, so that Matome should pray and be healed."* (Participant THP12)

> *"..That is the reason why even the Holy Scriptures say that even God said "I chose those who are undermined (overlooked). He may also say that "from an undermined household I chose a King". It does not mean that if we are traditional health practitioners we don't pray. We do pray. These things (African traditional and religious practices) are separated by us as people of flesh. They are actually one thing. If you are a traditional health practitioner, you are able to go to church. You are also able to pray."* (Participant THP11)

Another participant has gone further to indicate that sometimes with patients, they can be initiated into being healers which they may convert into prophesy and practice through religion in church.

> *"Sometimes, when you get to the church, they are also able to tell you that, here, you are in with one foot. Just go and practice your tradition. They can tell you that you should go and practice you tradition. When you are done with that, you can come back to the church. Then when you get to us, we are also able to check whether they can still fit into the church or not. Sometimes you may find that they (ancestors) say; now that you have done what we have instructed you to do, your things will run smoothly. That means you can prophesy people in church."* (Participant THP8).

As shown by the results of this study, there is a strong relationship between African traditional practice and religion. Healers acknowledge the existence of God, and some of them attend church. They further show that there is a possibility of being initiated through African traditional processes and later practice through Christian religion as a prophet.

7.3.13 Theme 7: A calling as symbolised by symptoms of mental illness

The outcomes of this study have shown that there are no standard treatment methods even with similar presentations of mental illness. Individuals with similar presentations may be treated through different procedures and with different treatment items as determined by the outcomes of the divination process. However, the results have further shown that some of the methods used in the treatment of mental illness may include among others, training to become a healer (go thwasa), to appease the ancestors (go phasa badimo), ingestion of oral medicines and prayer. These are explained further in the subthemes that follow.

Subtheme 1: Training to become a healer (go thwasa)

In the event of a calling, the ill person may be assisted through being initiated and trained towards being a healer (go thwasa / thwasiswa). The training reportedly encompasses the ill person being placed at the traditional health practitioner's place for the duration of the training process as they are taught what they have to know to become healers. This is demonstrated in the extracts below.

> *"...she must bring her blankets because she will be coming to stay with me for some time. She will now be initiated. There are things she must do in the morning and in the evening, that way. I will also be able to verify what I may have seen from the bones."* (Participant THP7)

> *"If it is about initiating him (thwasa), he is supposed to be here with me because there are certain things that he must always do. Again, there are certain things that he must be far away from. But it is possible for a person to be initiated while he is working; only coming to me on weekends. Since he is chosen, many of which he has to know, his ancestors will show him. It is a process. There is a treatment that we will be giving Matome. It will be helping him in bringing him and his spiritual ancestry (sedimo) together."* (Participant THP11)

For the participants, the process of initiation involves a lot of teaching from the healer to the trainee, the administration of certain medicines, the enhancement of the connection between the trainee and his or her ancestors, and continuous consultation of the divination bones.

Another participant has further demonstrated the different types of practitioners that may have a calling. They are tasked differently by their ancestors and they practice according to how they are guided after the process of initiation.

> *"People are not the same. There are spirits which may possess you and demand that you be initiated as a traditional healer to heal people. There are those who may demand that you be initiated only to perform in ritual dances (go bina malopo). If you perform in ritual dances, the person who possesses you gets satisfied. The third type of people is not the same as us. They don't use bones or to dance, they are just guided by their inner spiritual senses (ba bona ka lefahla)."* (Participant THP7)

The participant is of the view that not all individuals who get initiated into traditional health practice are bound to use divination bones as part of their practice. Others may be guided by their inner spiritual senses instead of divination bones. Others may have a calling to perform in ritual dances where they are led into seeing what troubles their clients and to assist in the process of treating them.

Subtheme 2: Opening of prophetic spirit (Go bulwa moya)

Another participant has shown that there are situations where a person may be ill due to a prophetic spirit that he has, which has to be opened up so that he can start to carry out the responsibilities of a prophet. This may at times be confused with the spiritual possession to become a healer. The processes of opening up the spirit (go bula moya) and training to become a healer (go thwasa) are reportedly different. The former is done through religious processes while the latter follows traditional health processes as reflected in the extract below.

> *"There is what we refer to as opening up the spirit (go bulwa moya) and there is thwasa (initiation). The opening of the spirit is religious while the thwasa is traditional. Even with Matome, we are going to consult the bones in order to know what he needs, what we have to help him with, and the medicines we have to give."* (Participant THP11)

As can be seen above, there is a thin line between a person who has to be initiated to become a healer and a person whose prophetic spirit has to be opened to practice. The results further demonstrate the difference between the traditional and religious healing processes in the management of symptoms similar to those of mental illness.

Subtheme 3: To appease and plead with the ancestors (Go phasa badimo)

In other situations, the results of this study suggest that a person may be ill due to the inheritance of the illness that the deceased had when they were still alive, especially if the ill person is named after them. The findings suggest that in cases where the ill person is said to be possessed by the spirits of the dead, either due to a calling or the inheritance of the illness that the deceased had when they were still alive, part of the treatment may involve pleading with the dead to release the ill person. The ill person may either be accompanied to the grave of the deceased, an open anthill or in the bush where the appeasing and the pleading will be done. The appeasing process involves kneeling and bowing the heads along with the rituals that have to be performed as shown in the extract below.

> *"If that is the case, we are going to accompany him to the grave of his grandfather, the one who is not well mannered. On our arrival, we shall kneel down and bow our heads, we do our rituals, and ask the grandfather to leave Matome alone because we do not deny the fact that Matome is renamed after him. So, please do not want him to do the same things as you were doing."* (Participant THP10)

> *"Helping him is that, he has to appease the ancestors (go phasa), and pray. This is because he is a type of person who must start by apologising more because he is now confused, and must ask for forgiveness because now he would be having a light (awareness). He can ask for forgiveness from an anthill which is open, from the grave or he can go to the bush."* (Participant THP11)

To the participants, appeasing the ancestors for them to release the ill person or for forgiveness in the case of a disregard of their messages assists in alleviating symptoms of mental illness. The bush, an open anthill or the grave of the ancestor who has to be appeased are viewed as contact points where appeasing rituals have to be performed.

The results have further shown that the treatment of mental illness involves the use of different items. The items may range from the roots of specific plants, other parts of plants, animal body parts and some western-based medicines in making concoctions to cure. The choice of treatment items, types of mixtures, and the treatment processes to be followed are prescribed by the bones during the process of divination as shown by the extract below.

> *"…we dig herbs. It can be "morotelatšhoši" here, or "mphera" there, we can dig them being ten traditional doctors. But, when we go to use them, we do not mix them in the same way. Each of us will respond in a manner that is being guided by the ancestors or the gods. It depends on how you are being guided, being directed to use for which purpose and on how to use it."* (Participant THP12)

The results further revealed that curing mental illness may involve the use of different treatment methods as prescribed by the divination bones, which may differ from one person to another. The treatment methods that healers often use may range from steaming with the smoke from heated stones and other added medicines (go arametša), throwing up/inducing vomiting (go kapa) and the ingestion of oral medicines among others. The extracts that are presented below support these assertions.

> *"There are things that he must often do, often pray, sometimes go to the water (rivers), often induce vomiting (go kapa), such things. If he is far away and I am treating him, I will tell him that this is oral medicine, and you take a full cup or half a cup once a day, and when you finish it, you must come back."* (Participant THP11)

"...if you can be able to make him inhale the first medicines, they are going to make him calm down. I get directed by the divination bones. If I see that he is not improving, I consult the bones again to ask for further guidance since the first medicines did not work." (Participant THP7).

"I will provide her with my medication so that she must not complain any longer. That means he or she will just sleep like a baby. She must forget all the bad things. Whether she has experienced what kind of problems, she will just forget. Then secondly, I will provide her with the medication for other illnesses which she is suffering from like high blood." (Participant THP10)

As can be seen above, there are many different treatment items and procedures in the management of mental illness by traditional health practitioners. Individuals with similar presentations may be treated differently as per the prescription of the divination bones.

7.3.14 Theme 8: Traditional health practitioners' views on the collaboration between themselves and western health practitioners

The findings of this study suggest that there is anticipation for the collaboration of traditional health practitioners and western health practitioners by the former. They have shown that it will help in complementing the latter with the services that they have limitations on, especially in managing a mental illness. This is because traditional health practitioners believe that there are conditions that have a traditional base in their causation and management as shown below.

"We wish it can happen because there are many people in hospitals who do not require the western medications but the African traditional medicines in their treatment." (Participant THP7)

"We will be happy about that because even though we know that there are certain conditions that can best be treated at the hospital, there are those which cannot be treated at the hospital, which are

> *best treated by us. Then, if we work together, we can help the nation."* (Participant THP8)

> *"...at certain times, there are conditions which the western practitioners are not able to treat, which needs traditional health practitioners. It is the same as other conditions which we are not able to treat, which we refer to hospitals."* (Participant THP11)

> *"...we are also free in the hospitals, we should know that this patient needs to be steamed up with smoke, we then take him to the private area, we then steam him up with smoke while is also taking the pills, because we do not say he must not take his pills. Patients will then drink traditional medicine and also western medicine in a routine way."* (Participant THP10)

The collaboration can best be achieved through the referral system between the western-oriented practitioners and the traditional health practitioners in the event of need.

> *"We are going to help sick people and send them to the hospital for water and blood transfusion because we don't have equipments for transfusions. That way, people will be healed."* (Participant THP7)

> *"We wish to achieve that through the manner of referrals. Such as when a person goes to see a doctor after which they give him a letter to go buy the medication from the chemist. Those are two things that work together.* (Participant THP11)

The participants have different views about where their location will be when rendering their services. Some participants feel positive about the idea of working from home as they might not want to inconvenience other people with different belief systems as well as some cultural restrictions on their items of use.

> *"I will appreciate working from home as there are types of healing in which you find that the divination bones do not have to go out of the yard. Sometimes we may not have a convenient place where we would put out medicines as there may be some prohibitions.'* (Participant THP11)

> *"We will appreciate the idea of working from home, where patients can be sent to us in our homes. This is because people have different beliefs. Working at the hospitals will be infringing on the beliefs of those who do not believe in traditional practices. Even the methods we use, I can give an example with steaming, and it will inconvenience those whose beliefs are not the same as ours."* (Participant THP8)

One participant on the other hand may be comfortable to have an office space in hospitals to be closer, which may help in cases of emergencies.

> *"Our wish is to be at the same place with them. If the western practitioners can agree to the idea of us having offices in hospitals, that is how we can manage it. If you see a patient who needs my services you are able to call me and send the patient to my office. Unlike now, where I have a car but I don't have a driver. By the time I get a driver and rush to the hospital, it may be late. A person may die while I am still looking for a driver."* (Participant THP7)

Another participant has demonstrated her view of finding convenience in working from their specialised institutions.

> *"We wish they should build hospitals for traditional doctors. So that when a patient did not get cure in the medical hospital, must be transferred to us. On the arrival, we then look amongst ourselves who knows that type of illness; because we also do not have the same power (speciality)."* (Participant THP10)

As can be seen from the examples above, there are positive views about the collaboration of traditional health practitioners and clinical psychologists in the management of mental health conditions. The only limitations that have been highlighted, which may need to be looked at in the implementation of the collaboration include the referral processes, location of operation and procedures. In their view, the collaboration will assist in the two systems complementing each other's limitations to the benefit of their service recipients as well as enhancing the holistic approach to treatment that acknowledges the spiritual element in human beings.

PART C: CONVERGENCES AND DIVERGENCES FROM THE FINDINGS

This study has managed to uncover the similarities and the differences in the formulations of mental disorders by clinical psychologists and traditional health practitioners, which will be presented below.

7.4 Convergences

7.4.1 The conceptualisation of stress and related conditions

The outcomes of the present study have uncovered that there is a similarity in the way mental disorders, particularly stress-related and depressive disorders are viewed by both clinical psychologists and traditional health practitioners. In the assertion by clinical psychologists, the condition that was illustrated in the first case of the study with the symptoms that include lack of sleep, hopelessness and helplessness, loss of appetite, social withdrawal and suicidal ideations, it is a clear case of major depressive disorder or depression in short. The extracts below demonstrate this assertion.

> *"I understand that the patient is not feeling well. Is undergoing some change in emotions or feelings. And this is actually affecting her performance. I am referring to performance in the family, or performance even at work. She sleeps most of the time. These are the symptoms of major depressive disorder."* (Participant CP1)

> *"These are the classical symptoms of depression. If there is now two weeks or more with her presenting with the symptoms she is presenting with, then it is clearly a major depressive disorder and not any other mood disorder."* (Participant CP4)

According to the traditional health practitioners, the symptoms of the case that was stated above are typical of stress-related and depressive disorders. This is demonstrated by the extracts that are below.

> *"..and then when she comes to us, you will find that we say she has "stress. Then I will tell her to go to the hospital. She must talk to them (hospital staff). Then when she comes back, and I check her, I will see that indeed this person has stress."* (Participant THP8)

> "*I may be troubled by my husband, taking me up and down until I have stress. If he does not change, it may no longer be stress, but change to become depression.* (Participant THP7)

> *"By the way, "stress" can make you confused. The stress due to the separation with her husband, that makes her tired, stressed and a different person". (Participant THP12)*

This indication shows the similarity in the understanding and formulation of stress-related disorders by these practitioners from two diverse systems; the western and the African healing systems.

7.4.2 Western system as the most appropriate in the management of stress-related and depressive disorders

According to most participants, both clinical psychologists and traditional health practitioners, the symptoms that are illustrated in the first case as those of stress-related and depressive disorders are best managed through the western approach. In formulation by clinical psychologists, the best place for these people to be referred to is the hospital where they will be treated. They further believe that stress-related and

depressive disorders are best treated through psychotherapy by psychologists and pharmacotherapy by doctors and pharmacists either in a hospital setting as inpatients or on regular visits to the hospital as outpatients. This is illustrated in the extracts that follow.

> *"Depression is mostly treated pharmacologically and also psychotherapeutically.* Someone will be subjected to medication first of all to stabilize their mood. Then when their mood is stable, we are able to provide them with psychotherapy*"* (Participant CP2)

> *"..with depression, depending on the risk assessment, the patient might be kept as an inpatient if suicide risk is high, or patient would be treated as an outpatient with the support of family members in the event of a low risk and the mental status of the patient."* (Participant CP5)

> *"..usually, my intervention also involves risk assessment. After my suicide risk assessment, if I find that the patient is of a high risk, I would admit and treat as an inpatient. If the patient is of a low risk, I would treat her as an outpatient." (Participant CP3)*

In addition to these assertions, traditional health practitioners also argued that the patient with symptoms similar to those in the first case of a stress-related and depressive condition is usually best treated through the western approach. They assert that when a patient with similar symptoms comes to them, once they realise that it is stress-related, they refer them to the hospital for treatment. They hold the view that the hospital personnel have the necessary expertise to manage such patients following which they can only treat the other related presented symptoms. These assertions are illustrated below.

> *"..and then when she comes to us, you will find that we say it is "stress". And when she is like that, we take her to the hospital. When a person has stress, they want to be put well (rearranged). I can try to*

put her well. But there will be where my abilities end." (Participant THP8).

"..she has kgatelelo ya monagano, (oppression of the mind / stress). The other thing is that conditions such as Mologadi's, we will not be able to help. They want her to go for "counselling". She will sit down and explain everything that is happening to her so that she can be helped. Now with us, things like "counselling" we are not able to do. From there we will consult the divination bones to find out if there are things that are remaining, which I can help her with." (Participant THP11)

From the findings, it thus appears that there seems to be consensus in the understanding of stress-related and depressive conditions between clinical psychologists and traditional health practitioners. from these illustrations, the western health system is considered by both clinical psychologists and traditional health practitioners as the appropriate place where stress-related conditions can be managed.

7.4.3 The benefits of the collaboration between the western and the african healing systems

The results of the study have shown that there is consensus in the appreciation of the envisaged collaboration between the western and African healing systems by both clinical psychologists and traditional health practitioners alike. The participants have further reported the likely benefits of the collaboration between the two systems which includes the holistic approach in the management of mental disorders and the acknowledgement of spiritual factors that are involved in the causation of mental disorders. The collaboration may create space for either of the two systems to learn how the other system operates. Below are the extracts that support these assertions by clinical psychologists.

"..looking at our people, you know, our people have a different way of life. We cannot rule out the issue of cultural or traditional issues. Even if we

do, they must still go on with their beliefs, you know, their treatment with their traditional healers or their religious system. If they bring them under one umbrella, one group will have the opportunity to learn how one group does their things vice versa. They might come to a stage where they work well together. Maybe that might help." (Participant CP1)

"*Well, I think it is a very good idea. I have already spoken about the biopsychosocial perspective, and I have realized that the perspective has been missing an element, that is the spiritual element. There are authors who are currently coming up with what is called the* ***extended biopsychosocial model*** *which then encompasses the spiritual element with our patients. That is, if we treat these patients from the three domains, we might miss out on the spiritual domain which may be a major contributing factor on how people interpret what they are going through. Therefore, I do not have any problem with the collaboration."* (Participant CP2)

"Psychology heals the mind and behaviour challenges which do not include spiritual problems. Referral to traditional healers will resolve the spiritual problems. There is therefore a need to work on research together which will help to understand conditions which have been difficult to manage, in a holistic way. Challenges will be found, but specific plans and rules will reduce them. There are some practitioners who have started to address these challenges, who are already referring." (Participant CP6)

In addition to the arguments by clinical psychologists, traditional health practitioners that were consulted in the study seem positive about the idea of the collaboration of the two systems with the idea of enhancing the management of mental disorders with particular consideration of the patients' spiritual needs. In some cases, as they argue, their inclusion in the management of mental disorders may compensate for the shortfalls of

the western healing system in the management of patients. This is supported by the illustrations below.

> *"We wish the collaboration can happen because there are many people in hospitals who do not require the western medications but the African traditional medicines in their treatment."* (Participant THP7)

> *"We will be happy about that. Because, even though we know that there are certain conditions that can best be treated at the hospital, there are those which cannot be treated at the hospital, which are best treated by us. Then, if we work together, we can help the nation."* (Participant THP8)

The findings seem to suggest that both systems concur with the idea of collaboration and hope for the better management of patients in a more holistic manner that also addresses their spiritual domains.

7.5 Divergences

7.5.1 The conceptualisation of the presenting symptoms from the two cases

The results of this study have shown that mental conditions are conceptualised differently by both clinical psychologists and traditional health practitioners. The former has shown that their formulations are in keeping with the western classification apparatus while the latter conceptualise mental disorders purely from the African traditional point of view. In the arguments made by the former, the two cases that were used in this study depict both major depressive disorder and schizophrenia respectively. This argument is shown by the extracts that are presented below.

The participants' views about the first case of depression

> *"I understand that the patient is not feeling well. Is undergoing some change in emotions or feelings. And this is actually affecting her performance. I am referring to performance in the family, or performance even at work, because she sleeps most of the time. When I look at it, what comes to my mind is* ***Major Depressive***

Disorder. *These are the symptoms of major depressive disorder."* (Participant CP1).

"I understand the case as a case that is presenting someone with depression. I think most of the symptoms that the patient is presenting with are more of, you know, ***depressive symptoms.*** *This is based on how I was trained obviously."* (Participant CP2)

The participants' views about the second case of schizophrenia

"Okay. I understand the case of Matome to be that of a psychotic disorder. With the disorganization of behaviour coupled with delusions and hallucinations it is clear that Matome has somewhat lost touch with reality. I think it is a case of schizophrenia." (Participant CP3)

"My understanding of the second case is that, we are now faced with a person who has lost touch with reality. He is distorted in terms of their thinking, distortions in terms of their perceptions about themselves and the world at large. We could be talking about what we refer to in psychology as psychosis. Yes, for me it sounds like schizophrenia." (Participant CP2)

"This looks like a Brief Psychotic Disorder on the basis of the available symptoms. However, it could still be anything ranging from this diagnosis to schizophrenia depending on the more information I get from the collateral sources." (Participant CP6).

Contrary to the conceptualisations by the clinical psychologists, traditional health practitioners understand the presentations in the cases as a calling, social contamination (lekgoma), or ancestral possession. These arguments are supported by the extracts that are presented below.

"..according to our tradition, and the way I see Mologadi, especially if she struggles for sleep, according to me, Mologadi may be

possessed by the spirits of people who have died. When we look at it, especially the symptoms, we may just say that Mologadi has an "ancestral possession"." (Participant THP8)

"..we are going to refer to it as the illness of the Gods "ancestors", although with him, he did not pay attention to it. It is not mental illness or anything. It is that of the "ancestors". He did not pay attention to it until the point where he got confused (mixed up) mentally. Then it will end up as if it is mental illness while it was not actually mental illness." (Participant THP9)

"..a person with a calling, whom his paths come in different ways. To many people, it is rare to find them being employed. And when such things happen to them, they comply and carry them out well on time. .. Yes. It is because of a calling that he has, which he never paid attention on or investigate." (Participant THP11)

"There is one illness called social contamination or social pollution (Makgoma/Lekgoma). It is a kind of illness that is normally caused when spouse, children, relatives died and you are not cleansed at all or even not properly cleansed. Or sometimes you sleep with a woman who has just lost her partner and she is not cleansed. Sometimes it hides itself. This social contamination (Lekgoma) makes a person when trying to do this and that, not to succeed in life, being always asleep, being tired, and tired of thinking." (Participant THP12)

It can therefore be argued that the two healing systems formulations and diagnoses of similar presentations are diverse.

7.5.2 The causal factors of mental health conditions

It was discovered from the findings of the study that both clinical psychologists and traditional health practitioners understand the causes of mental illness differently. The former associate mental illness with biological, psychological and social causal factors.

These factors are said to include stressors of different kinds, chemical imbalances, financial, social, and environmental as well as genetic and hereditary factors. This is supported by the illustrations below.

> "*Major depressive disorder is a heterogeneous illness with a lot of causes. Starting from biological causes where you find that there is a chemical imbalance, such imbalance of neurotransmitters like dopamine and serotonin, the person can be prone or vulnerable to being depressed. There may also be psychological issues such as a person's personality, a person's poor coping skills, a person's inability to accept themselves, and you know, a person's negative thoughts that they think about themselves. There may also be lack of optimism in life. Those are the psychological factors that can contribute to one having depression."* (Participant CP2)

> *"There are many explanations to the causation of schizophrenia. Schizophrenia can be explained by biological factors such as hereditary and genetic explanations. It can be passed through the genes, hormones and chromosomes from one generation to another. Furthermore, there can be some issues which Matome might have gone through such things as the experimentation with substances."* (Participant CP3)

> *"Depression is caused by a lot of factors. In this situation it might be work related pressure, unfulfilling education, cognitive distortions- negative thought. It may be caused by other medical conditions such as HIV. HIV alters one's makeup of the brain cells and how they should function. An alteration in their formation and function may cause mental illness."* (Participant CP6)

> *"They may range from a medical condition, including hormonal, psychological including stress induced depression, negative thought cognitions and other factors or the cause might be social including*

poor coping skills, a trauma, relationship conflicts, financial troubles or other stressful life events." (Participant CP5)

Contrary to the former, traditional health practitioners understand mental illness to be emanating from either a calling by ancestors, a result of bewitchment for different reasons, or inheritance by virtue of naming. Bewitchment that causes mental illness is associated with either jealousy or vengeance as a result of either crime or witchcraft. These arguments are supported by the illustrations that follow.

"Sometimes, you may find that in Matome's household, there was one ancestor who died while he was a Christian. Maybe he was an Apostolic member. Maybe any church. You may find that ancestor wants Matome to follow his footsteps and continue as a Christian. Sometimes you may find that is just us Sotho people (witchcraft). Sometime, you may find that Matome is the one who was assisting his mother at home. We said we have spoiled or turned off his mother. We bewitch this Matome." (Participant THP10).

"*According to us, Matome may not be ill. He may have thought it was God yet it was his grandfather talking to him. Saying to him that I have chosen you my child, and I want you to carry out my work which I was doing because I am gone. I left my things there. They are covered up and my duties are halted. I want you to continue doing what I was doing. Matome may have ignored the call hence he decided to make him a roamer to roam around."* (Participant THP7)

Even though there may be many causal factors attributable to the presentation similar to those in the cases under investigation, most of the causes as understood by traditional health practitioners have much to do with spirituality.

7.5.3 The initial methods of enquiry

The participants in this study have shown diverse methods through which they enquire the patients when they first get into contact with them. The clinical psychologists have

reported about their use of clinical methods of enquiry that include an interview with the patient as well as the collateral sources to understand the patient and determine the condition that they are dealing with. These assertions are represented by the extracts that are presented below.

> *"Matome's medical history is not known as of yet. With that in mind, there could be other medical conditions that could lead him into psychosis. There could be quite many explanations to the causation of schizophrenia; hence a comprehensive history taking is very important."* (Participant CP3)

> *"..usually, in treating the condition, I would like to have the collateral information from the family to help me understand better, when the problems started, if there were any triggers, any stressors so to say. So, I would interview the family members and then I would interview the client in order to make my own diagnosis and come to the conclusion about my clinical impressions."* (Participant CP4)

> *"..it is important to get collateral information from his family or anybody who was with him when everything started in order to get more information."* (Participant CP1)

In contrast, the traditional health practitioners have shown much reliance on the throwing of divination or knucklebones as a sole method of enquiry through which they are guided about the condition, its cause and the prescription of its management and the items to be used.

> *"..I get directed by the divination bones. If is see that he is not improving, I consult the bones again to ask for further guidance since the first medicines did not work."* (Participant THP7)

> *"I am guided by the divination bones. There is nothing more important than being guided by the divination bones because conditions are different, people are different, and what they want is*

different. If you cannot make it a point that you are guided by the bones, you will get into trouble." (Participant THP8)

"..we consult the divination bones. When we finish, we are able to tell him that, yes, Matome, there is a voice that you once heard by you did not pay attention and comply." (Participant THP11)

The findings of this study thus argue that, in the view of traditional health practitioners, the only point of enquiry is the divination bones. They help to diagnose and guide the treatment processes as well as the items to be used, which may differ from one patient to another.

7.5.4 The management of mental health conditions

This study has revealed that clinical psychologists and traditional health practitioners manage mental disorders in diverse ways referring to their divergent belief systems. On one hand, clinical psychologists believe in psychotherapy and pharmacotherapy as the methods through which mental disorders can be treated. Psychotherapy is further informed by the problem at hand as well as the theories from which they are formulated. This is supported by the extracts below.

*"..mostly we use **cognitive** therapy where we try to help the patient to correct whatever distortion or negative thoughts that might be going on or she may be going through, so that she can begin to see life in a different way."* (Participant CP1)

"I have used a variety of therapeutic techniques based on the root cause of the depression including CBT to address negative cognitions, family-focused therapy to address family relationship conflict as well as various other therapeutic modalities." (Participant CP5)

In contrast, traditional health practitioners believe in the traditional methods and items as the apparatus for the management of mental disorders. The management process is

further determined by the guidance that the healer gets through the process of divination with the divination bones. This is illustrated by the extracts that follow.

> *"I am going to start by preparing to cook medication for her to drink. Thereafter, I will heat stones for treating her with steam. In that case, I will be ensuring that her mind comes to her senses."* (Participant THP12)

> *"..we will consult the divination bones to find out if there are things that are remaining, which we can help her with."* (Participant THP11).

The findings seem to suggest that there is no given method of treatment of mental disorders from the African traditional point of view. The intervention is determined by the findings from the process of divination, and so are the items to be used.

7.6 Conclusion

The present chapter has begun by presenting the demographic details of the participants who were interviewed. The chapter further presented the themes and subthemes as they emerged from the data that was gathered from the traditional health practitioners and clinical psychologists. Though there are differences in the conceptualisations of mental disorders between the two approaches from which they practice, the study has found some commonalities in their view of mental disorders. The next chapter will present an integration of the results and the available literature as guided by the themes and subthemes to address the gap that the study aims to fill.

CHAPTER EIGHT

DISCUSSION OF THE FINDINGS

8.1 Introduction

This chapter aims to discuss the findings of the study within the context of the existing body of knowledge in terms of the role that traditional health practitioners and clinical psychologists play in the management of mental illness. The first section of this chapter covers the clinical psychologists' conceptualisations of selected mental illnesses. In this section, issues such as the role of collateral information in the assessment and treatment of mental illness, classifications, symptomatic manifestations, causes, the role of the multidisciplinary team in the management of mental illness, as well as the positive and negative views regarding the collaboration of western and African traditional health practitioners are discussed.

The second section of this chapter presents the traditional health practitioners' conceptualisations of selected mental health cases. This section discusses issues such as; divination as the main process of enquiry, descriptive names of mental illness, the commonalities in the conceptualisations of stress-related and depressive disorders between clinical psychologists and traditional health practitioners, causal factors, types of mental illness best treatable in the western health system, the relationship between Christian religion and African traditional practices, calling as a symptom of mental illness, and traditional health practitioners' advocacy of collaboration between the western and African traditional practitioners.

8.2 Summary of the research findings

8.2.1 Clinical psychologists' conceptualisation of selected mental illnesses

8.2.1.1 The role of collateral information in the assessment and treatment of mental illness

This study has revealed the importance of collateral information in the process of information-gathering, assessment and management of mental illness as reported by

psychologists. Emphasis was put more on the depth of information, further suggesting that the more in-depth the information, the easier it becomes for the clinical psychologists to have rich information that will assist in the process of assisting the patient. In the same light, surface information has been reported as a hindrance in the process of intervention when dealing with patients with mental illness. The results of this study concur with the assertions by Petrik, Billera, Kaplan, Matarazzo and Wortzel (2015) who argue favourably the role of collateral information in facilitating comprehensive mental health care, further maintaining consistency with recovery-oriented models. They further bring awareness to challenges faced by service providers in obtaining consent from patients to obtain information from third parties, further indicating the importance of observation of ethical and legal regulations. Austin (2002) also notes the importance of collateral information from third parties, especially in the assessment of the credibility and validity of information from primary sources in the assessment of child custody cases.

Despite the assertions of the importance of collateral information, it may not be without shortfalls. This is demonstrated in the study by Breda, Rovaris, Vitola, Mota, Blaya-Rocha, Salgado, Victor, Picon, Karam, Silver and Rohde (2016) where collateral information has no bearing on attention-deficit/hyperactivity disorder symptoms by adults with a self-reported history of the condition as it happened in childhood. Witkin (2019) concurs with the former authors by illustrating the importance of collateral information, especially during the admission of psychiatric patients. He further warns, despite the usefulness of collateral information, about the tendency at times, for such information to be misleading and its ability to create a false bias.

8.2.1.2 Classifications of mental illness

The international classifications of mental illness such as the Diagnostic and Statistical Manual of Mental disorders fifth edition (DSM 5) as well as the International Classification of Disorders tenth edition (ICD 10) group mental disorders into categories due to the similarities of their main symptoms. This present study used the vignettes of major depressive disorders and schizophrenia to obtain and compare the information

from clinical psychologists and traditional health practitioners on their conceptualisation of the two illnesses within their contexts. The results seemed to acknowledge the idea of classification of mental disorders which is in line with the classification systems that are in place currently. The information obtained from clinical psychologists has shown that there are many categories of mental illnesses as per classification, with the first case belonging to depressive disorders while the second falls within the schizophrenia spectrum and other psychotic disorders in the DSM 5.

Through their acknowledgement of classification systems in place to categorise mental illness, Jacob and Patel (2014) argue that although psychiatrists may prefer to use labels of disorders, primary health workers often prefer the utilisation of dimensions of various forms of distress for the presentation of common mental illnesses due to their discomfort with the usage of such labels which to them seem insensitive. Clark, Cuthbert, Lewis-Fernández, Narrow and Reed (2017) supports the argument by indicating that the two major diagnostic manuals, the DSM 5 and the ICD 11 are in place to provide public health-specific classification systems referring to clinical diagnosis, service provision and specific research application. However, contrary to the two systems, the National Institute of Mental Health's Research Domain Criteria incorporates behavioural and neuroscience research to expand the understanding of mental illness. Despite significant efforts to unite these differing classification systems, Gask, Klinkman, Fortes and Dowrick (2008) emphasizes the significant discrepancies resulting from how each of these systems views the clinical domain of mental illness. In the words of Stein, Lund and Nesse (2013) there seems to be a significant day-to-day clinical utilisation of constructs depicted from the classification systems into the future.

8.2.1.3 Symptomatic manifestations of depression and schizophrenia

From the perspective of clinical psychologists, the findings of this study have uncovered that mental illness concerning depression and schizophrenia is often manifested through emotional and physical symptoms. Depression manifests through the presence of emotional and physical symptoms that include diminished interest, weight loss or gain, loss of energy, tiredness, feelings of hopelessness and helplessness, guilt,

psychomotor retardation, agitation, difficulty in concentration to suicidality. The findings have further shown that the symptoms of depression may occur in isolation or in combination with symptoms of other illnesses. These findings are supported by the assertion by Kumar, Srivastava, Paswan, and Dutta (2012), who argue that the symptoms of depression are subject to its severity, with symptoms closer to normality in their milder form and suggestive of psychosis and suicidality in their severest form. They have further listed some of the common symptoms some of which are parallel to the findings of this present study, which include a depressed mood, low self-worth and guilt feelings, appetite and/or sleep disturbances, low energy, poor concentration and loss of pleasure or interest.

These arguments and the findings of the study are in agreement with the assertion by WHO (2012) which denotes that the diagnosis and severity classification of depression is dependent on the number and severity of symptoms as mild, moderate or severe, as well as the areas and extent of their effect on one's functioning. In addition to the common symptoms of depression, Trivedi (2004) points out other physical symptoms such as chronic joint pain, limb pain, back pain, gastrointestinal problems, tiredness and psychomotor activity changes that are associated with depression, yet often not considered as significant. In other cases, symptoms of depression may incorporate the slowing down of movement and speech, agitation, restlessness, pacing up and down, loss of sexual desire and weight changes (Goldman, 2019).

Schizophrenia was presented as a type of mental illness that may be associated with emotional and behavioural symptoms that include paranoia, social withdrawal, lack of emotional expression and motivation, speech and behaviour disorganisation, aggression towards people and property, avolition to catatonia. The argument by Kahn *et al* (2015) supports the findings of this study by emphasising the psychotic nature of schizophrenia as characterised by a combination of such symptoms as delusions, hallucinations, disorganization in terms of speech and behaviour, and motivational and cognitive dysfunctions. Mosotho *et al* (2011) support the findings by indicating that even though cultural variables are important in diagnosing schizophrenia, there are no

differences in the presentation of schizophrenia between Sesotho-speaking individuals and the general population.

Contrary to the outcomes the former authors, Ensink, Robertson, Hodson and Tredoux (1998) had reported a similar spectrum of common symptoms though with a higher prevalence of aggressive and disruptive behaviour, persecutory and sexual fantasy delusions, self-neglect and irritability in South African Xhosa-speaking individuals as compared to their English-speaking counterparts. An addition made by Patel Cherian Gohil and Atkinson (2014), states that there is a disability that is secondary to schizophrenia, which can be accounted for by the early onset as well as the chronicity as perpetuated by the negative symptoms such as attention impairment, diminished working memory and other executive functions. Odinka, Ndukuba, Muomah, Oche, Osika, Bakare, Agomoh and Uwakwe (2014) indicate that the duration of untreated psychosis is viewed in Nigeria as a significant predictor of illness outcome. In the same light, negative symptoms of schizophrenia are less considered as mental illness and are rather associated with deviant behaviour or spiritual problems that require spiritual intervention.

8.2.1.4 Causes of mental illness

i. Biological causes of mental illness

The findings of the present study as reported by clinical psychologists have revealed that mental illness may be a result of biological, psychological, social and environmental causal factors either in isolation or in combination. Biological factors associated with mental illness include chemical imbalances, underlying medical conditions, thyroid problems, genetic and hereditary problems. This finding is supported by the biological theories on the causation of mental illness with depression and schizophrenia included.

The findings of the study on biological causes of mental illness are supported by authors like Corey (2009) who attributes abnormal behaviour suggestive of mental illness to be resulting from malfunctions in certain parts of the brain anatomy or chemistry of an organism. Butcher *et al* (2013) also postulate that mental illness occurs

through hereditary factors, biological processes, pathological processes in the central nervous system, autonomic nervous system or the endocrine system of the brain, or structural damage to the brain cortex. In their view, such processes may happen in isolation or in conjunction with other social and psychological causal factors. According to Deacon (2013), most of the listed biological causal factors have been found to account for the aetiology of major depressive disorders, schizophrenia, attention-deficit/hyperactivity disorders and substance-related disorders.

ii. Psychological causes of mental illness

Personality make-up, poor coping skills, cognitive distortions such as negative automatic thoughts, underlying unexpressed difficulties, trauma and pessimism all account for the psychological causality of mental illness. The findings are parallel to the assertions made by psychological theories on the aetiology of mental illness

Many psychological theories attribute psychological causal factors of mental illness to developmental and internal psychological processes. From the point of view of the psychodynamic theory, mental illness results from the unconscious and unresolved internal conflicts, interruptions of the development of the id, ego and superego that constitutes the human psyche (Freud 1924; 1933; Corey, 2009; Corsini & Wedding, 2008). Behaviourists attribute the causes of mental illness to the faulty processes of learning behaviour (Bernstein *et al,* 2012). The proponents of cognitive behavioural theory assert that mental illness may result from faulty thinking which may, in turn, affect behaviour and mood (Keegan & Holas, 2009).

iii. Environmental and social causes of mental illness

Mental illness may at times result from social and environmental factors in the form of loss of a loved one through death, loss of a relationship, work-related stressors, loss of employment, financial stressors, the use of recreational substances, marital problems, poverty and peer pressure. This argument is in keeping with what many authors of social theories have alluded to as aetiological factors of mental illness.

The arguments made by the participants of the study are consistent with literature that suggests that environmental factors are at times responsible for the aetiology of mental illness. Heekin and Polivka (2015) indicate that numerous environmental factors in the form of life stressors such as death, divorce, changing schools and financial problems often perpetuate negative mental health outcomes. Social variables relating to such factors often include nutritional deficiencies, chronic medical disorders, environmental pollutants, high temperatures and rural geographical location maximises the chances in these regards. Schmidt (2007) contributes by indicating that factors such as sexual abuse, nutritional deficiencies, falling victim to crime or the ending of a relationship are accountable for psychosocial stress and mental illness. Elliot (2016) asserts that poverty is a risk factor for mental illness while at times it may also serve as a causal factor and a consequence of mental illness.

9.2.1.5 The role of a multidisciplinary approach in the management of mental illness

From the findings, it is evident that clinical psychologists understand mental illnesses such as depression and schizophrenia as conditions that may best be managed through the incorporation of a multidisciplinary approach that involves themselves, pharmacists as well as medical practitioners. They have shown that patients with these forms of mental illness follow the process of medical practitioners' assessment and medical prescriptions, dispensing of medication by pharmacists to stabilise them, and psychological assessment and intervention by clinical psychologists when they become medically stable. The participants perceive symptom severity and the level of risk involved as determinants of the location in which the patient will be managed such that severely depressed or psychotic patients are managed as in-patients while patients with less severe symptoms are managed as outpatients.

These findings are consistent with the assertion that the management of both acute and chronic depression involves the application of either a psychological or pharmacological form (Hanwella, 2008) or a combination of the two systems (Timonen & Liukkonen, 2008). Patients with schizophrenia have also been found to benefit from both pharmacological treatment and psychosocial treatment to provide social support,

enhancing treatment adherence and preventing relapse (Rasool, Zafar, Ali & Erum, 2018; McDonagh *et al,* 2017). Psychosocial interventions have also been found to complement and address inherent challenges that may arise in the sole use of pharmacological treatment, especially in patients with acute-phase schizophrenia (Saayman, 2010). The outcomes are further supported by Majeed, Ali and Sudak (2019) who have found cognitive behavioural therapy as a form of psychological intervention to be effective when applied as an alternative or adjunct to opioids in the management of medical challenges such as chronic pain. The importance of a multidisciplinary approach is echoed by Kumar, Sinha, Khanna and Kar (2013) through its ability to address the limitations by one profession in the management of child and adolescent depression as psychiatrists, clinical psychologists and psychiatric social workers and other allied professionals collaborate to complement each other to enhance the effectiveness of the treatment.

8.2.1.6 The views regarding the collaboration of western and african traditional health practitioners

From the findings of this study, there were a number of both positive and negative factors which may influence the possibility of collaboration between traditional health practitioners and clinical psychologists.

Clinical psychologists have reported that the collaboration between traditional health and the biomedical systems will have positive outcomes in the promotion of patient autonomy, enhancement or complementation of either system by another, incorporation and acknowledgement of spiritual factors. Collaboration is also reportedly likely to provide platforms of information and knowledge exchange between the two systems to do away with the held misconceptions of one system by another. There is not enough literature to support the assertions by clinical psychologists in their support of the benefits of collaboration with traditional health practitioners in the management of mental illness.

The support of the move for collaboration is found in the literature on other allopathic professionals in the management of other medical conditions, such as the study by

Green and Colucci (2020) which was aimed at reviewing studies of traditional health practitioners and biomedical practitioners' perceptions on collaboration in Zanzibar, Tanzania. As was the case with traditional health practitioners, biomedical practitioners were of the view that patients with mental illness could benefit from the two systems' collaboration. This was supported by Solera-Deuchar, Mussa, Ali, Haji and McGovern (2020) who also argued that both biomedical and traditional health practitioners are in favour of the support for collaboration in the management of mental healthcare. Biomedical health practitioners acknowledged the contribution of traditional health practitioners in the provision of mental health services, further encouraging bi-directional referrals between the two systems.

In addition to the support of the movement for collaboration between the two systems, Mendu (2016) further asserted that biomedical practitioners recommend the use of traditional medicine externally to avoid its interaction with ARVs in the management of HIV. The study by Madiba (2010) which was aimed at determining the biomedical health practitioners' views on collaboration with traditional health practitioners in the Tutume sub-district of Botswana, identify existing collaboration activities. He further determined that collaboration approaches that were acceptable by the former showed support for collaboration by the biomedical health practitioners. From the findings, biomedical health practitioners supported the move, despite their acknowledgement of low levels of collaboration and low levels of awareness of the policies on collaboration. In the argument by Ryan, Hirt and Willcox (2011), the Taskforce for Skin Care for All: Community Dermatology supports the collaboration with traditional health practitioners in the management of skin diseases. This is based on the fact of the traditional health practitioners' accessibility, and local knowledge about the people and medicinal plants, availability and affordability of traditional medicinal resources, client-centeredness, cultural appropriateness, holistic interventions, and their ability to offer family counselling.

Contrary to the positive outcomes, other psychologists have discussed the negative factors that may impede the envisaged collaboration efforts. Psychologists have noted with concern such issues as the unscientific training and practice of traditional health

practitioners, lack of policies tailored to facilitate the smooth process of collaboration and the differing worldviews of the two systems are perceived as challenges that may hinder the collaboration. This argument is supported by the findings of Nemutandani, Hendricks and Mulaudzi (2016) who found western health practitioners resistant to working with traditional health practitioners due to challenges, that include the quality of health care, the differing concepts of science and sources of knowledge, and the lack of clear collaboration policies.

Hlabano (2013) and Opaneye and Ochogwu (2007) further argues that the differences between the two systems are exacerbated by their differing views on the causation of illness. Western practitioners view illness as a result of physical causes while traditional health practitioners look at many factors that include spiritual causal factors. Van Rooyen, Pretorius, Tembani and Ten Ham (2015) add to this by indicating that there seem to be negative attitudes between western health practitioners and traditional health practitioners which contribute to delays and/or impossibilities of collaboration between the two systems. Campbell-Hall, Petersen, Bhana, Mjadu, Hosegood, Flisher and MHaPP Research Programme Consortium (2010) echo the disinterest by western health practitioners in working with traditional health practitioners in the findings of their study.

8.2.2 Traditional health practitioners' conceptualisation of selected mental illnesses

8.2.2.1 Divination as the main process of inquiry

The outcomes of this study have revealed the amount of value that traditional health practitioners attach to the process of divination. They consider divination as the main tool which enables the process of tapping into their clients' world to understand and help them further. Azongo and Abubakari (2014) define divination as the mechanism that is employed to gain a vision or knowledge about a situation or particular question through the use of mystical, supernatural, or magical powers, practices, processes or rituals.

The traditional health practitioners in this regard have highlighted their reasons for first consulting their bones to include:

a) Seeking clarity about the nature, cause, and other related factors of the main complaint,

b) Avoidance of attempting to treat conditions that may have resulted from the ill person's mischievous acts, which may, in turn, affect the healer if they have attempted to intervene, and

c) Seeking direction regarding the treatment procedures to be followed and the items to be used.

The results have echoed the postulate by Atindanbila and Thompson (2011) who acknowledges that African traditional health practitioners make use of the patients' history, family history, physical examination, and most importantly, divination for diagnostics. Divination has always been at the heart of healing in Africa (Ashforth, 2005). It is part of the ancient health-seeking practices and is still persistent in many societies in Ghana. Divination serves to complement the health needs of the people, especially in traditional rural societies also often used in acute situations in isolation or in combination with other health services to obtain a cure to sicknesses (Azongo & Abubakari, 2014).

The participants' assertions are supported by the results of the study by Azongo and Yidana (2015) who argue that many diseases, especially those whose aetiological perceptions are embedded in the worldview of the local people require consultations with diviners. Diviners use different items that include cowries mixed with stones and bones, river sand, sticks and water to trace the source of the pain. In the process of divination, diviners use burnt dried flowers and stems to invoke ancestral spirits that help and guide them during the process of divination (Sobiecki, 2014). They make use of different objects that represent different aspects of a person's life such as birth, happiness, riches and death to get into contact and access the person they are assisting. Such objects are thrown to the ground like dice. From these items'

configurations, they draw and interpret solutions. Such objects further serve as a link between the diviners and their spirits (Omonzejeje, 2004; Fombe, 2017). The participants of this study have shown their trust in the guidance they receive from their divination bones during the process of divination as they attempt to understand their clients before they can help them.

8.2.2.2 There are many descriptive names of mental illness

The findings of this study have revealed that mental illness, like other forms of illness, from the African traditional point of view, has more descriptive than definitive names. The participants have identified some of the descriptive names that come to mind when they see the presentation of symptoms of cases in the appendix. The listed illnesses include, *makgoma* (social contamination), *kgatelelo ya monagano (*oppression of the mind/stress*), go hlakana hlogo (*mental confusion*), go gafa/Bogaswi (*madness*), and go swarwa ke badimo (*ancestral possession*)*.

Zabow (2007) hypothesises that there are explanatory categories and descriptive names of mental illness such as ukuthwasa (calling to be a healer), amafufunyana (possession by evil spirits) and ukuphambana (madness) which are used by traditional health practitioners, which are different from names used by western practitioners. The argument was further echoed by Makgabo (2012) who argued that mental illness, especially childhood mental illness is better understood if described than defined

8.2.2.3 Commonalities in the conceptualisations of stress-related and depressive disorders between clinical psychologists and traditional health practitioners

The findings of the present study have found some common perceptions that traditional health practitioners and clinical psychologists have about stress-related and depressive disorders. The symptoms of the case that is represented in Appendix 2A, which is characterised by lack of sleep, hopelessness and helplessness, loss of appetite, social withdrawal and suicidal ideations were seen to be representative of stress and depressive disorders by both traditional health practitioners and clinical psychologists.

In as much as mental illness can be a global concept, illness is understood in terms of the cultural connotations attached to it. Gureje and Stein (2012) argue that the symptoms of any particular illness are experienced and understood within the cultural milieu and culture within which they are presented and are influenced by norms with which patients and their families are familiar. This notion endorses the help-seeking pathways sought by the families or the affected individuals. Although there may be commonalities in the way depression, among other conditions, was viewed by Africans, it was a concept understood by Africans in an African way that may be different from how it is viewed by the west. Starkowitz (2013) concurs with these arguments by asserting in the findings of her study that from the perspective of the traditional health practitioners, there is an element of understanding of depression which is secondary to the level of the practitioner's acculturation into the western culture and exposure to biomedical interventions.

8.2.2.4 Factors attributable to the causes of mental illness

This study has uncovered from the traditional health practitioners' conceptualisations that mental illness may result from various causal factors. They have identified causal factors for the types of illnesses that were represented in the case vignettes as ranging from *witchcraft by others, either due to revenge or jealousy, disregarding an ancestral calling, to it being inherited from the person one is named after.* However, there seemed to be an agreement between traditional health practitioners and clinical psychologists about mental illness often resulting from normal life stressors.

Though there are many causal factors as differentiated by cultural and normative elements of socialisation, the results seem to agree with the outcomes of the study by Stefanovics, He, Cavalcanti, Neto, Ofori-Atta, Leddy, Ighodaro, & Rosenheck (2016) who argue that individual conceptions of mental illness and its treatment often reverberates the normative and cultural notions within which they are interpreted. The view and interpretation of the causation of mental illness which is often attributable to evil spirits and God's work is common in most cultures and religions of the world. Sokhela (2016) also echoes the assertions from the community level, about the

associations between mental illness and witchcraft which may happen as a result of a bright learner's book or pen being stolen or a woman being bewitched by her mother-in-law due to jealousy. All of which justifies the community's beliefs about their association of mental illness and witchcraft.

Campbell, Sibeko, Mall, Baldinger, Nagdee, Susser and Stein (2017) echoes the perceptions of members of the southern African communities about witchcraft as perpetuated by jealousy and emphasises the role that culture plays in informing the content of delusions, from the viewpoint of their Xhosa participants. In the assertion made by Monama and Basson (2015) culture and religion informs how individuals perceive and make sense of their illness especially during its early phases, despite patients' compliance with their psychiatric treatment. Cultural beliefs further contribute to one's help-seeking behaviour as the findings of the study by Basson and Gilks (2018) showed that participants often sought spiritual help which determines the meaning they attach to their illness, especially in the early phases of their illness.

The study by Razali, Khan and Hasanah (1996) found that there was high statistics of individuals who consulted traditional health practitioners for mental illness in Malaysia. Both the patients and the traditional health practitioners held the same common belief that mental illness was caused by supernatural agents such as witchcraft and possession by evil spirits. This outcome was supported by the findings of the study by White (2015) who reported the causes of ill-health from the African point of view to be resulting from such factors as disobeying of taboos, attacks from evil spirits, disconnection with, and ill-treatment of, ancestors, witchcraft and spell-casting. Neba (2011) concurred with these authors, categorising four causal factors of mental illness, namely natural causes associated with acts of God, moral and ritual infringements, the ignorance of taboos and ancestral spirits. These are in keeping with the findings of the study by Aina (2004) who also reported that the causes of mental illness are supernatural, including sorcery-related spiritual attacks, witchcraft and curses from enemies, gods or deities.

8.2.2.5 Some mental illnesses are best treated in the western health system

It was evident from the findings of this study that traditional health practitioners highlight their limitations with the management of some mental health issues, with stress-related and depressive disorders in particular. Traditional health practitioners have reported their ability to manage physical ailments such as persistent worry and hypertension which are reportedly often related to, or secondary to, stress-related and depressive disorders. They have further indicated the effectiveness of western biomedical practitioners in the management of stress-related and depressive conditions.

The findings of this study are supported by a postulation by Risal (2011) who argues that the management of mental illness has always been carried out through the application of either pharmacology or psychosocial intervention or a combination of both as rendered by western health practitioners. Zabow (2007) further justifies the reason why African psychiatric patients often seek treatment from traditional health practitioners while primarily consulting with psychiatric clinics. This argument brings forth many differing viewpoints about the benefits and disadvantages of collaboration and the parallel use of different modalities in South Africa. Patients with depression have shown a great improvement when put on SSRIs while patients with schizophrenia respond well on Clozapine despite the severe side-effects associated with it (Norquist & Hyman, 1999).

Psychotherapeutic approaches to an intervention like psycho-education, motivational enhancement and cognitive behavioural counselling have proven effective when combined in the management of substance abuse outcomes when dealing with its co-morbidity with another mental disorder (Mueser, Drake, Sigmon & Brunette, 2005). The combination of treatment modalities has been ascertained by De Jong (2011) especially in the form of social support, cognitive behavioural techniques and pharmacotherapy in the management of acute mental illness. This is supported by Solera-Deuchar, Mussa, Ali, Haji and McGovern (2020) who reveals that symptoms of what seems to be mental illness can best be treated in a hospital or clinic facility as compared to traditional health facilities.

8.2.2.6 The relationship between Christian religion and African traditional practices

As opposed to the common notion that there is no relationship between Christianity and the African traditional practices, the findings of the study have found that a relationship does exist between the two systems and how they complement each other. The traditional health practitioners who participated in the present study have acknowledged the existence of God. Others have reported that they even go to church, while others gave reports of their incorporation of prayer in their traditional intervention with their patients as determined by the patients' choice and need. The relationship between the two systems was ascertained by the reports that suggest that other people are initiated into traditional healing, which they later convert into prophesy and use within the Christian context.

The findings of this study have disputed the ideology that was presented by many authors before. Mumo (2018) demonstrates how Western missionaries have always not recognised African traditional religion, dismissing it from Christianity, and further condemning the African traditional practices and associating them with devilish practices. In the view of the Manianga of Zaire, according to Mulemfo (1995) God, Nzambi Mpungu as they refer to Him uses ancestors (bakulu) to reveal medicinal plants and their use to healers for the restoration of health. However, the idea of their belief in ancestors as mediators between God and the people has been dismissed by missionaries. The relationship is further ascertained by Morekwa (2004) who argues that African people often have a tendency of seeking healing from traditional health practitioners as well as western practitioners and go to church at the same time.

8.2.2.7 Mental illness as a symbol of ancestral calling

The present study has uncovered the differences in terms of the views and conceptualisations about the meaning of symptoms of mental illness between traditional health practitioners and clinical psychologists. The traditional health practitioners have demonstrated that it is not always the case that symptoms are suggestive of mental illness. Symptoms may often appear as a communication from one's spiritual world in a prescriptive manner, or they may symbolise an ancestral calling. In instances of an

ancestral calling, the participants argue that the bearer of those symptoms must go through the apprenticeship to either become a traditional health practitioner (go thwasa), to open up one's prophetic spirit for prophetic use (go bulwa moya), or to appease the ancestors (go phasa badimo). Kahn and Kelly (2001) argue in line with the findings of the study by suggesting that diviners are often called into their profession through a manifestation of symptoms of a sickness understood as "*thwasa"*. After the presentation of those symptoms, a lengthy initiation process begins under the guidance of another diviner which transits them into becoming diviners.

Booi (2004) further argues that the symptoms associated with an ancestral calling often referred to as "*intwaso"* may manifest themselves by appearing as anxiety, mental confusion, visual and auditory hallucinations, fear, delusions, mood swings, social isolation, violence and aggression, and poor personal hygiene. Mutwa and Mutwa (1996) adds that sometimes they experience persistent and excessive dreams which may be characterised by the content of water and rivers, submerging in the river or immersing themselves in a river. Kubeka (2016) also argue that even in the Zulu tradition, people with an ancestral calling often present with symptoms that are similar to those of mental illness, or psychosis. Such persons have to go through an apprenticeship of "*ukuthwasa*" to be healed from their symptoms and become traditional health practitioners.

8.2.2.8 Traditional health practitioners' advocacy for collaboration between them and western health practitioners

The participants in the present study have expressed their anticipation for the idea of collaboration between the western and African traditional health practitioners in the management of illness, mental illness included. Some of the advantages listed by the traditional health practitioners in this regard include the fact that the two systems will complement one another especially on services that may have a shortfall for either of the systems. In addition, the traditional system will complement the western system, especially in conditions and situations which have a cultural basis. They have expressed their interest in the collaboration taking the form of a referral system between

the two systems. The findings of the study by Campbell-Hall, Petersen, Bhana, Mjadu, Hosegood, Flisher and MHaPP Research Programme Consortium (2010) indicates that even though traditional health practitioners have noticed the lack of appreciation by western health practitioners, they showed openness to training in the western health approaches and cooperation in the collaborative relationship in the interests of the improvement of patient care. This is further supported by Akol, Moland, Babirye and Engebretsen (2018) who acknowledges the biomedical practitioners' disregard and unwillingness to collaborate with the traditional health practitioners despite the latter's willingness to collaborate.

In the words of Hillenbrand (2006), traditional health practitioners are aware of the weaknesses within their system, which motivates their willingness to collaborate and learn from the biomedical system to be integrated into the national public health strategy. Some formal workers have also shown their support for the integration of the traditional health practitioners into the mainstream health system (Masupha, Thamae and Phaqane, 2013). In addition to the aspirations for collaboration, the findings of the study by Keikelame and Swartz, (2015) shows the traditional health practitioners interest in the collaboration strategy that will take into account the protection of their intellectual property, accountability, respect for indigenous knowledge and the promotion of cultural literacy, especially among mental health care practitioners.

In terms of the location of operation, some participants felt they would appreciate working side-by-side with western practitioners in the existing mainstream health institutions. Others have expressed their interest in seeing the erection of centralised African traditional health facilities which may treat patients who come to consult, those who are referred from western institutions and further refer those who may need western medical attention to western institutions. Lastly, some participants have shown their interest in working from home where all of their items will be closer to them as opposed to working outside their homes, which might pose a limitation in their access to the items they may need to use.

8.3 Convergences and divergences from the findings

8.3.1 Convergences

8.3.1.1 The conceptualisation of stress and related conditions

Stress is one of the main conditions that most patients in both western and African traditional health facilities present with, amongst other problems. There seems to be concurrence between western and traditional health practitioners about their understanding of stress-related conditions. For psychologists, studies have uncovered a relationship between stress, anxiety disorders and depression, and further argued that it is detrimental to always consider the physiology of stress and its consequences on the psychological wellbeing of individuals (Khan & Khan, 2017). Depression has also been found to impact negatively on an individual's quality of life. Even though the aetiology of it remains unclear, there is evidence of the impact of imposed psychological stress contributing to depression (Yang, Zhao, Wang, Liu, Zhang, Li & Cui, 2015).

It has been evident that traditional health practitioners acknowledge the element of stress amongst mental health challenges that their clientele often presents with. This is supported by the findings of the study by Zabow (2007) who argues that traditional health practitioners in his study acknowledged the practice of psychotherapy on their side, which aims to address patients' stressful life events and to advise them on the tasks that they may engage in to alleviate this stress. Starkowitz (2013) also support this argument by indicating that traditional health practitioners acknowledge the element of depression, differentiate it from extreme sadness, treats it, and further admits to external and psychosocial circumstances as contributory factors in depression. Their awareness in this regard was associated with the level of acculturation into westernised cultures as well as their exposure to the biomedical health system. Molot (2017) further endorses this assertion by indicating that traditional health practitioners have a good level of understanding of psychotic disorders as mental illnesses. However, they have less understanding and less attention towards non-psychotic disorders, further classifying them as stress. These assertions suggest that both traditional health

practitioners and clinicians are aware of stress and somehow have a more or less similar understanding of it.

8.3.1.2 The benefits of the collaboration between the western and the african healing systems

The results of this study have revealed a consensus that exists in the views of both traditional health practitioners and clinical psychologists about the benefits of collaboration of the two systems. They have supported this assertion by indicating that the collaboration with help with, among others, a learning opportunity of one system and its way of doing things by another, the incorporation of spirituality in the holistic treatment of individuals with mental illness and the opportunity of referrals between the two systems for the improvement of care.

In support of this argument, the study that was conducted by Hlabano (2013) has found a positive outcome of collaboration between traditional health practitioners and clinical psychologists. From these findings, traditional health practitioners experienced transformation through the gain of knowledge, particularly on HIV-TB epidemiology through the training they received from allopathic health practitioners. The idea of strengthening traditional health practitioners' capacity and the collaboration of traditional health practitioners and allopathic health practitioners have also been found to be contributing positively to building a stronger health care system (Rainatou, Souleymane, Salfo, Mohamadi, Rene, Alimata & Sylvin, 2021). Mokgobi (2014) indicate the successes that collaborative initiatives had in other African countries, particularly as a result of favourable perceptions and attitudes that western health care professionals have towards traditional health practitioners.

8.3.2 Divergences

8.3.2.1 The causal factors of mental health conditions

The findings of the study have revealed that the aetiology of mental health conditions is viewed differently by both clinical psychologists and traditional health practitioners. The perception of the former is more in keeping with the biopsychosocial model as

discussed in chapter five while the perceptions of the latter can be associated with African cultural and spiritual factors. The findings of the study by Belayneh, Abebaw, Amare, Haile and Abebe (2019) further associate other factors such as being female, lack of formal education, an age of 25 years and above, unemployed and living in extended families with the causes of schizophrenia. Another study by Worku and Shiferaw (2014) emphasizes social and psychological factors such as unemployment, mental health treatment defaults, substance use, socioeconomic problems, family conflict, loss of family members, poor social support, academic failure and repeated chronic illnesses among others as contributory factors to the aetiology of mental illness. These factors are associated with the causation of schizophrenia, major depression disorder, brief psychosis and anxiety disorders.

In opposition to the views of clinical psychologists, traditional health practitioners held different perceptions about the causes of mental illness. The findings revealed that, in their view, mental illness may emanate from bewitchment, hereditary factors, the disregard of ancestral calling and other factors. These findings are supported by the results of the study by Sigida (2016) that has shown that being bewitched or cursed, smoking dagga or being involved in accidents, experiencing stressful life events and heredity is associated with the causation of mental illness. Ngobe (2015) supports this argument by maintaining that supernatural powers such as witchcraft, spirit possession, evil mechanisation, disregarding of ancestors and cultural customs, substance use, genetic predisposition and life stressors among others are responsible for the causation of mental illness. Monama and Basson (2015) agree with other authors who associated mental illness with ancestral dissatisfaction, further arguing that mental illness associated with ancestral dissatisfaction is not life-threatening, and health is restored once the relationship with the ancestors is mended through rituals and offerings.

8.3.2.2 The initial methods of enquiry

There have been some discrepancies that were revealed by the study about the methods of inquiry between traditional health practitioners and clinical psychologists. According to Mokgobi (2014) diviners, a speciality within traditional health practice uses

bones and the spirits of their ancestors in the process of diagnosing, prescribing medications for various physical, psychiatric and spiritual ailments. Schizophrenia and spiritual possession are also reportedly some of the conditions that they treat through the same processes. Haque, Chowdhury, Shahjahan and Harun (2018) have revealed in their study that was conducted in Bangladesh that the processes used by African traditional practitioners in their diagnostic and treatment process involve spirituality and communication with sacred spirits. Mothibe and Sibanda (2019) supported this argument by emphasising the traditional health practitioners' reliance on spirit possession, the use of divination bones and dreams as their main diagnostic methods

On the other hand, according to Oluwatosin and Popoola (2018), clinical psychologists strive to assist their clients, whereas psychologists always have to understand their clients and their presenting concerns. Their level of understanding of their clients is determined by the depth of information they acquire from and about their clients through interviews, testing and assessment procedures. Segal, June and Marty, (2010) supports this assertion by arguing that it is the ability to conduct an effective and efficient clinical and diagnostic interview that determines the level of skill required in mental health practitioners. It is in this interview that the clinician can make some inferences about the client, further being able to determine intervention and the professional relationship that is required. Doyle (2016) adds to the argument by indicating that a clinical interview, generally a semi-structured interview and specific psychometric assessments form a comprehensive set that helps in addressing the referral question

8.3.2.3 The management of mental health conditions

Due to the utilisation of both the western and the African health modalities by service users, traditional health practitioners expressed positivity in the proposed collaborative initiative. They have also expressed their willingness to learn the operations of the western treatment modality for the benefit of their service recipients (Campbell-Hall, Petersen, Bhana, Mjadu, Hosegood, Flisher & MHaPP Research Programme Consortium, 2010). Even though traditional health practitioners welcome the idea of collaboration, and are willing and looking forward to it, they acknowledge the disregard

of the authenticity of their services by allopathic health practitioners (Akol, Moland, Babirye & Engebretsen, 2018). The outcomes of the study by Solera-Deuchar, Mussa, Ali, Haji and McGovern (2020) also revealed that some traditional health practitioners welcomed the idea of collaboration with allopathic health practitioners as it would provide a platform for learning additional skills from the allopathic practitioners.

On the contrary, there seems to be some resistance from the allopathic practitioners about the collaboration (Campbell-Hall, Petersen, Bhana, Mjadu, Hosegood, Flisher & MHaPP Research Programme Consortium, 2010). Although the patients understand the need for this collaboration, the resistance between the two systems gives rise to the need for both systems to get to an understanding of the possible institutionalisation of the traditional health system into the mainstream health system (Hardy, 2008). Oseni and Shannon (2020) further acknowledge the discrepancies between the two systems and state that the power struggle between the two systems may serve as a hindrance in the efforts to foster success in the collaboration of the two systems.

8.4 Conclusions

This chapter was intended to discuss the findings of the study within the milieu of the existing body of knowledge about the role that traditional health practitioners and clinical psychologists play in the management of mental illness. The chapter commenced by presenting the clinical psychologists' conceptualisations of selected mental illnesses. The issues which were covered are the role of collateral information in the assessment and treatment of mental illness, classifications, symptomatic manifestations, causes, the role of the multidisciplinary team in the management of mental illness, and the positive and negative views regarding the collaboration of western and African traditional health practitioners.

The second part of this chapter presented the traditional health practitioners' conceptualisations of selected mental health cases. The issues which were discussed under this section include divination as the main process of enquiry, descriptive names of mental illness, the commonalities in the conceptualisations of stress-related and depressive disorders between clinical psychologists and traditional health practitioners,

causal factors, types of mental illness best treatable in the western health system, the relationship between Christian religion and African traditional practices, calling as a symptom of mental illness, and traditional health practitioners' advocacy of collaboration between the western and African traditional practitioners.

CHAPTER NINE

SUMMARY AND CONCLUSION

9.1 Introduction

The first part of this chapter will present the summary of findings of the study given the three key findings, that is clinical psychologists' conceptualisation of selected mental illnesses, traditional Health Practitioners' conceptualisation of selected mental illnesses, and the views on a collaboration of western and African traditional health systems. The chapter will present the implications of this study in theory, policy and future research. The chapter will refer to the Afrocentric and Biopsychosocial theories. The third and last part of the chapter will discuss the limitations that were identified in this study.

9.2 Summary of the research findings

9.2.1 Clinical psychologists' conceptualisation of selected mental illnesses

9.2.1.1 The role of collateral information in the assessment and treatment of mental illness

The findings of the study have revealed that clinical psychologists rely more on the availability and the depth of collateral information in the process of diagnosing and treating mental illness. They have indicated that less information may hinder the process of intervention while more detailed information may assist the psychologist in exploring further the factors that emerge from it, which adds value to the intervention process.

9.2.1.2 Classifications of mental illness

The results have further indicated that the cases which were used in the study (see appendix 2A and 2B) are of major depressive disorder and schizophrenia respectively. They have also shown that there are many categories of mental illnesses as per classification, with the first case belonging to depressive disorders while the latter falls within the schizophrenia spectrum and other psychotic disorders in the DSM 5

9.2.1.3 Symptomatic manifestations of depression and schizophrenia

This study has revealed that, from the point of view of clinical psychologists, mental illness in the form of depression and schizophrenia may be manifested through emotional and physical symptoms. Depression is often seen as symptoms that may range from diminished interest, weight loss or gain, loss of energy, tiredness, feelings of hopelessness and helplessness, guilt, psychomotor retardation, agitation, difficulty in concentration to suicidality. At other times, the symptoms of depression may co-occur with symptoms of other mental illnesses.

Schizophrenia may also present itself with emotional and behavioural symptoms that may range from paranoia, social withdrawal, lack of emotional expression and motivation, speech and behaviour disorganisation, aggression towards people and property, avolition to catatonia.

9.2.1.4 Causes of mental illness

The participants of this study have revealed that mental illness may result from biological, psychological and social and environmental causal factors. Biological factors may include chemical imbalances, underlying medical conditions, thyroid problems, genetic and hereditary problems. Psychological factors may range from one's personality makeup, poor coping skills, pessimism, trauma, cognitive distortions such as automatic negative thoughts and underlying unexpressed difficulties. Lastly, social and environmental factors may include the death of a loved one, loss of a relationship, loss of employment, work-related stressors, financial stressors, marital problems, recreational substances, peer pressure and poverty.

9.2.1.5 The role of a multidisciplinary approach in the management of mental illness

Clinical psychologists have understood mental illness in respect of depression and schizophrenia as conditions that are best and successfully treated through a multidisciplinary approach. There is an involvement of the clinical psychologist for psychological intervention, the doctor for medical assessment and prescription of medication as well as the pharmacist who dispenses the prescribed medications. They

have further indicated that the severity of symptoms and the level of risk involved determine the location at which the patient is placed during treatment. Severely depressed or psychotic patients are managed as in-patients while patients with less severe symptoms are managed as outpatients.

9.2.1.6 The views regarding the collaboration of clinical psychologists and traditional health practitioners

Clinical psychologists highlighted some positive and negative factors that may affect the process of collaboration between traditional health practitioners and clinical psychologists.

The collaboration of the African traditional health system and the western biomedical health system may assist in the promotion of patients' autonomy, enhance complementation on both systems, incorporate and acknowledge the spiritual element of human beings, which is often ignored by the western biomedical health system, the gaining of more knowledge of the two systems about each other, and nullification of misconceptions.

On the other hand, the psychologists have identified some of the factors that may serve as hindrances in the process of collaborating between the two systems. These factors may range from unscientific training of traditional health practitioners, lack of legislative frameworks for the governance of the collaboration as well as the different conceptual orientations that these two systems operate from.

9.2.2 Traditional health practitioners' conceptualisation of selected mental illnesses

9.2.2.1 Divination as the main process of inquiry

The traditional health practitioners have revealed that their first point of entry in their interaction with their clients is through the use of divination bones. Their decision to use bones first is informed among others by the following reasons

a) Seeking clarity about the nature, cause, and other related factors of the main complaint,

b) Avoidance of attempting to treat conditions that may have resulted from the ill person's mischievous acts, which may, in turn, affect the healer, and

c) Seeking direction regarding the treatment procedures to be followed and the items to be used.

9.2.2.2 Descriptive names of mental illness

The study has further revealed that mental illness from the traditional health practitioners' point of view is often more described than defined. They have further identified some of the descriptive names of mental illness that include *makgoma* (social contamination), *kgatelelo ya monagano (*oppression of the mind/stress*), go hlakana hlogo (*mental confusion*), go gafa / Bogaswi (*madness*), and go swarwa ke badimo (*ancestral possession*)*.

9.2.2.3 Conceptualisations of stress-related and depressive disorders between clinical psychologists and traditional health practitioners

The findings of this study have revealed that there is a common ground in terms of how clinical psychologists and traditional health practitioners perceive stress-related and depressive disorders. This argument followed the participants' conceptualisation of the case that is presented in Appendix 2A, which is characterised by lack of sleep, hopelessness and helplessness, loss of appetite, social withdrawal and suicidal ideations. The symptoms were understood as those of stress-related or depressive disorder by both clinical psychologists and traditional health practitioners.

9.2.2.4 Factors attributable to the causes of mental illness

The findings of this study have shown that, from the point of view of traditional health practitioners, mental illness may have various causal factors. These may include normal life stressors which concur with the assertion made by clinical psychologists. Other causes include witchcraft by others, either due to revenge or jealousy. The traditional

health practitioners have further argued that mental illness may also result from a disregard of a calling by one's ancestors, or it may be inherited from the person one is named after.

9.2.2.5 Some mental illnesses are best treated in the western health system

Traditional health practitioners in this study have reported that they are not able to manage stress-related and depressive disorders. They are only able to manage physical ailments such as persistent worry and hypertension which may be related to stress-related and depressive disorders. They consider the western biomedical system to be the more suitable place to manage such conditions.

9.2.2.6 The relationship between christian religion and african traditional practices

The findings have shown that there is a positive relationship between Christian religion and African traditional practices which complement one another. The participants have acknowledged the existence of God, with others indicating that they go to church. Some have reported that they incorporate prayer in their treatment of patients. The findings further suggest that some are initiated into traditional healing, which they later convert into, and practice as prophecying in a Christian religious context.

9.2.2.7 Calling as a symptom of mental illness

The findings of the study have revealed that the symptom spectrum of mental illness from the perspective of traditional health practitioners may be symbolising other factors that are not a mental illness. They may often appear as a communication from one's spiritual world in a prescriptive manner. They may mean that the person presenting with those symptoms must be trained to become a traditional health practitioner (go thwasa), one's prophetic spirit having to be opened up for prophetic use (go bulwa moya), and one having to appease the ancestors (go phasa badimo).

9.2.2.8 Traditional health practitioners' advocacy for collaboration between them and western health practitioners

Traditional health practitioners have demonstrated positive views about the idea of collaborating between western and African traditional health systems in the management of mental illness. The traditional health practitioners have expressed that the collaboration will help by one system complementing the other, especially in services that either system has limitations in managing, specifically with conditions that have a cultural basis. In their view, collaboration can best be achieved through a system of referral from one system to another. The participants have further presented differing views regarding their location of practice in the event of collaboration with others. Some suggestings were to work from home, be given offices in the mainstream health institutions, and working in African traditional and western specialised institutions separately.

9.2.3 Convergences and divergences from the findings

This study revealed some convergences and divergences in the conceptualisations of mental illness by both traditional health practitioners and clinical psychologists. Both the western and African health practitioners that were consulted shared the same feelings about stress and stress-related conditions. Secondly, they held similar views about the positive outcomes that may emanate from the process of collaborating the two systems, especially in the management of mental health conditions. However, some themes demonstrated discrepancies in their views on other issues. They have shown divergences in their methods of enquiry, their views about causal factors of mental health conditions and the management processes of such conditions.

9.3 Implications of the findings

9.3.1 Implications of the study on the theory

The present study drew from the Afrocentric and Biopsychosocial theories to understand conceptualisations of mental illness by traditional health practitioners and clinical psychologists respectively.

9.3.1.1 The afrocentric theory

From the point of view of traditional health practitioners as sources of information in the present study, cultural and spiritual factors are at the centre in the causation, progression, treatment and prevention of mental illness. The researcher involved the traditional health practitioners as custodians of the information that is embedded in the African traditional practices by Africans. This argument is in keeping with the Afrocentric theory which puts Africans at the centre of information that concerns Africans. Their understanding, formulation and conceptualisation of mental illness draws from African theories without any infiltration of western-based information that misrepresents Africans.

The findings further demonstrated commonalities in the views of traditional health practitioners, about cultural and spiritual factors contributing more to the causation, treatment and prevention of mental illness. Their view of mental illness does not take into consideration any biological factors as causal and maintaining factors in mental illness, as is the case with the western biomedical theories. It is therefore imperative to always take into cognisance the cultural and contextual aspects in dealing with mental illness.

9.3.1.2 The biopsychosocial theory

The findings of this study have revealed that biological, social and psychological factors either in isolation or in combination play a role in the causation and maintenance of mental illness as illustrated by the findings from the clinical psychologists. There is less consideration of cultural and spiritual factors in the causation of mental illness as is the case with the findings obtained from the traditional health practitioners. The arguments presented in this regard suggested that the biopsychosocial theory as one of the western biomedical theories plays a huge role in the formulation and management of mental illness by psychologists. The findings of this study concur with the biopsychosocial theory and make it pivotal and practical in the conceptualisation and management of mental illness within the South African context.

9.3.2 Implications of the study on policy

The findings of this study have revealed that there is high utilisation of African medicine that runs parallel to western medicine in the management of mental illness in South Africa. In addition to the African Traditional Health Act that regulates the registration and practice of traditional health practitioners, there is a need for the development of more policies that will integrate the African health system and the western health system for them to participate reciprocally to benefit the health of all South Africans.

As the future looks brighter for the long-awaited collaboration between the African traditional health system and the western health system, the government may need to put policies in place that should outline the process of collaboration. Such policies should direct the process in terms of ethical guidelines, procedures and hierarchical protocols to foster mutual respect and avoid dominance of one system by another.

It can further be argued that there is a need for future policies that should help in the protection and preservation of the wealth of knowledge of African traditional practices for future reference. The endorsement of such policies may assist in the encouragement of more traditional health practitioners to participate openly and confidently in the continuous provision of health services in South Africa.

9.3.3 Implications of the study on future research

This present study, as well as many previous studies, continues to acknowledge the critical role that traditional African medicine play in the care, prevention and cure of different illnesses in African communities. There is a need for more future studies that will contribute positively to the wealth of knowledge as far as African medicine is concerned, especially in mental health. It is also pivotal to have more future studies that will continue to advocate for and ease the process of envisaged collaboration between western and African medicine in the management of mental illness.

9.4 Limitations of the study

Like many preceding studies, this study also has some shortfalls. This section presents some limitations that may have been encountered in this study. The study used a sample of 06 clinical psychologists and 06 traditional health practitioners. This renders the sample of the study small and further suggests that the findings of this study may not be generalised to represent all clinical psychologists and traditional health practitioners in the Capricorn District of the Limpopo Province. Future studies in this regard may need to consider larger samples for the findings to represent a larger population.

Secondly, the gender distribution of this study consisted of more females in both the clinical psychology and traditional health categories than was the case with males. This indicates that the voice of males was less heard and represented in the findings as opposed to the female voice. It is therefore recommended that future studies may need to consider a fair distribution of males and females for the outcomes to be generalisable to both genders.

Thirdly, the researcher, as a clinical psychologist, conducted interviews with clinical psychologists and traditional health practitioners for information gathering. This might have resulted in in-depth and rich data that represents the views of psychologists as compared to that of traditional health practitioners as created by their being less represented in the data collection process. To mitigate this factor, in future comparative studies of this nature, researchers may need to consider traditional health practitioners as co-researchers for a fair representation of their facts and views within the context they are intended for.

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Appendices

Appendix 1A: Participant consent letter and form (English Version)

Department of Psychology
University of Limpopo
Private Bag X1106
Sovenga
0727
Date_____

Dear Participant

Thank you for showing an interest in participating in this study that looks at the case formulations on selected mental health conditions by clinical psychologists and traditional health practitioners: a comparative analysis. The purpose of this study is mainly to understand the analysis of clinical formulations by clinical psychologists and indigenous healers in the Polokwane Municipality.

Your responses to this individual unstructured interview will be treated as highly confidential, and the researcher will treat your identity and name as confidential and will not, in any way, disclose them with the results of this study. Please be informed that participation in this study is voluntary, and you thus have the right to terminate the continuations of the interview at any time.

Kindly answer all the questions to the best of your ability. Your participation in this study is very important. Thank you for your time.

Sincerely

_____ _____
Jones Makgabo Date
Doctoral student

_____ _____
Prof. Sodi Date
Supervisor

Consent Form

I_____ hereby agree to participate in this research project which focuses on the comparative analysis of case formulations on selected mental health conditions by clinical psychologists and traditional health practitioners.

The purpose, terms and conditions of the study have been thoroughly explained to me and I understand my rights and freedom in participating in this study. I also understand my freedom and the right I have to terminate the continuation of this study should I feel like discontinuing my participation at any time.

I understand that the outcomes of this study will not benefit me personally, and I also understand that my identifying details provided in this form will not, in any way, be linked to the results of this study. I understand that my name and answers in this study will remain confidential.

Signature _____

Date _____

Appendix 1B: Letlakala la tumelelano ya batšeakarolo le formo ya tumelelano

Department of Psychology
University of Limpopo
Private Bag X1106
Sovenga
0727
Date_____

Motšeakarolo yo a hlomphegago

Ke leboga go bontšha kgahlego ga gago ka go tšea karolo mo nyakišišong yeo o sekasekago kwišišo ya kalafo malwetši a monagano ao a kgethilwego go ya ka ditsebi tša monagano le mangaka a setšo. Maikemišetšo a nyakišišo ye ke go sekaseka le go bapetša menkgwa yeo ditsebi tša monagano le mangaka a setšo ba e šomišago go kwišiša malwetši a monagano.

Dikarabo tša gago mo poledišanong ya bobedi bja rena di tla swarwa bjalo ka sephiri, gape monyakišiši o tla swara boitsebišo le leina la gago bjalo ka sephiri gomme a ka se di tšweletše le dipoelo tša nyakišišo ye. O lemošwa gore botšeakarolo mo nyakišišong ye bo ka boithaopi, gomme o na le tokelo ya go emiša poledišano ya rena nako efe kapa efe.

O kgopelwa go araba dipotšišo go ya le ka moo o ka kgonago, ka ge botšeakarolo bja gago mo nyakišišong ye bo le bohlokwa. Ke leboga nako ya gago.

Ka boikokobetšo

_____ _____
Jones Makgabo Date
Moithuti wa Doctorate

_____ _____
Prof. Sodi Date
Mohlahli

Formomo ya tumelelano

Nna _____ ke dumela go tšea karolo mo nyakišišong yeo o sekasekago kwišišo ya kalafo malwetši a monagano ao a kgethilwego go ya ka ditsebi tša monagano le mangaka a setšo.

Maikemišetšo le mabaka ao a beilwego ka nyakišišo ye a hlalošitšwe ka botlalo gomme kea a kwešiša. Gape ke kwešiša le ditokelo le bolokologi bja ka mo botšeakarolong bja nyakišišo ye. Ke kwešiša gape le bolokologi le tokelo ya ka ya go emiša ka tšwelopele nyakišišong ye ge ke nyaka go emiša ka go tšea karolo nako efe kapa efe.

Ke a kwišiša gore dipoelo tša nyakišišo ye di ka se nkhole ka bonna, ke kwešiša gape le gore tshedimošo ya ka ya boitsebišo yeo e filwego foromong ye e ka se amantšhwe le dipoelo tša nyakišišo ye. Ke a kwešiša gore leina la ka le dikarabo tša ka di tla swarwa bjalo ka sephiri.

Signature _____

Date _____

Appendix 2A: Vignette – Major Depressive Disorder

Mologadi is a 42-year-old female who has various degree qualifications. She is an attorney by profession and works for a large law firm. She is successful in her work. She is divorced with two children; a son aged 9 and a daughter aged 14.

She has recently demonstrated the following symptoms: difficulty sleeping, poor appetite, poor concentration, feelings of tiredness and demotivation. She frequently feels down without any apparent reason. She often forces herself to wake up to go to work during the week and sleeps most of her weekends. Due to her lack of sleep, she often experiences mostly negative thoughts. There have been times that she has contemplated suicide, but she has never acted on such thoughts.

Adapted from: Austin, T., Bezuidenhout, C., Botha, K., Du Plessis, E., Du Plessis, L., Jordaan, E., Lake, M., Moletsane, M., Nel, J., Pillay, B., Ure, G., Visser, C., Von Krosigk, B. & Voster, A. (2015). *Abnormal Psychology: A South African Perspective*. 2nd Ed. South Africa: Oxford University Press Southern Africa (Pty) Ltd

Appendix 2B: Vignette – Schizophrenia

Matome is a 22 years old man who is currently in hospital. He was in Gauteng when his symptoms appeared. He was hospitalised there, and as soon as his symptoms stabilised, his father fetched him and brought him back to Polokwane.

After about eight months, while still in Gauteng, Matome's behaviour started to change, and he started to display the following symptoms:

- He woke up one evening and saw a bright light and heard what he considers the voice of God. The voice told him that he was special and that he was 'the chosen one'.
- He started roaming around, untidy, sometimes half-naked, singing and chasing people. He also believed that he was in love with a white woman and that they were going to marry soon.

- His personal hygiene deteriorated. He withdrew into his room and became socially isolated. As a result, he lost his job and became dependent on other people in the hostel for financial assistance.
- The main feature was that he continuously heard what he considers the voice of God, who constantly gave him instructions.

The other people in the hostel became concerned about Matome and realised that something was seriously wrong. They forced him to visit the hospital where he was finally admitted.

Adapted from: Austin, T., Bezuidenhout, C., Botha, K., Du Plessis, E., Du Plessis, L., Jordaan, E., Lake, M., Moletsane, M., Nel, J., Pillay, B., Ure, G., Visser, C., Von Krosigk, B. & Voster, A. (2015). *Abnormal Psychology: A South African Perspective*. 2nd Ed. South Africa: Oxford University Press Southern Africa (Pty) Ltd

Appendix 3A: Interview guide

Objective	Interview questions
1. To understand and describe the conceptualisation of the causes of mental disorders by traditional health practitioners and clinical psychologists.	a). I would like you to share with me your understanding of the case that has just been presented to you.
	b). What name would you give to the condition that has just been presented to you?
	c). Based on your experience, kindly explain the causes of such a condition.
2. To determine what traditional health practitioners and clinical psychologists consider to be the nature of the presenting mental disorder as reflected in the case vignettes.	d). In your view, what type of condition is it that you heard/read?
	e). Other than what is reflected in the case, what are the other symptoms and signs that will be associated with such a condition?
3. To examine the traditional health practitioners and clinical psychologists' understanding of the appropriate treatment that should be provided to the presenting problems reflected in the case vignettes	f). How would you go about treating this condition if you were requested to intervene? Also share with me how you have treated such a condition in the past.
	g). I would like you to share with me the methods and procedures that you would use to treat such a condition.
	h). Where would a patient with such a condition be kept whilst you are busy treating him/her?

Appendix 3B: Lenaneohlahlo la dinyakišišo

Diphihlelelo	**Dipotšišo tša nyakišišo**
1. Go kwišiša le go hlaloša kwišišo ya seo se hlolago malwetši a monagano go ya ka mangaka a setšo le ditsibi tša monagano.	a). Nka thabela gore o abagane le nna ka kwišišo ya gago ka kanegelo yeo e sa tšwago go anegwa go wena?
	b). Ke leina lefe leo o ka le fago bolwetši bjoo bo sa tšwago go anegwa go wena?
	c). Go ya ka boitemogelo bja gago, ka boikokobetšo hlalosa seo se hlolago bolwetši bjo.
2. Go akanya seo go ya ka mangaka a setšo le ditsibi tša monagano ba se bonago bjalo ka dika tša tšweletšo ya malwetši a monagano ao a tšweleditšwego mo dikanegelong.	d). Go ya ka pono ya gago, bolwetši bjo o bo badilego/kwelego ke bolwetši bja mohuta mang?
	e). Ka ntle le seo se tšweleditšwego mo kanegelong ye, ke dika dife tše dingwe tšeo di ka amantšhwago le bolwetši bjo?
3. Go ahlaahla kwišišo ya mangaka a setšo le ditsibi tša monagano mabapi le seo ba se bonago bjalo ka mokgwa wa maleba was go alafa malwetši a monagano ao a tšweleditšwego mo dikanegelong.	f). O be o ka phetha bjang go alafeng bolwetši bjo ge o be o ka kgopelwa? Gape abagana le nna ka moo o ilego wa alafa bolwetši bja mohuta wo nakong ya go feta.
	g). Nka thabela gore o abagane le nna mabapi le mekgwa le magato ao o bego o ka a latela go alafa bolwetši bjo.
	h). Ke kae moo molwetši wa mohuta wo a bego a ka bewa ge o sa tshwaragane le go mo alafa?

Appendix 4: Ethical clearance

University of Limpopo
Department of Research Administration and Development
Private Bag X1106, Sovenga, 0727, South Africa
Tel: (015) 268 3935, Fax: (015) 268 2306, Email: anastasia.ngobe@ul.ac.za

TURFLOOP RESEARCH ETHICS COMMITTEE

ETHICS CLEARANCE CERTIFICATE

MEETING: 6 August 2019

PROJECT NUMBER: TREC/199/2019: PG

PROJECT:

Title: Case Formulations on Selected Mental Disorders by Clinical Psychologists and Traditional Health Practitioners: A Comparative Analysis
Researcher: CJ Makgabo
Supervisor: Prof T Sodi
Co-Supervisor/s: Dr S Nkoana
School: Social Science
Degree: PhD in Psychology

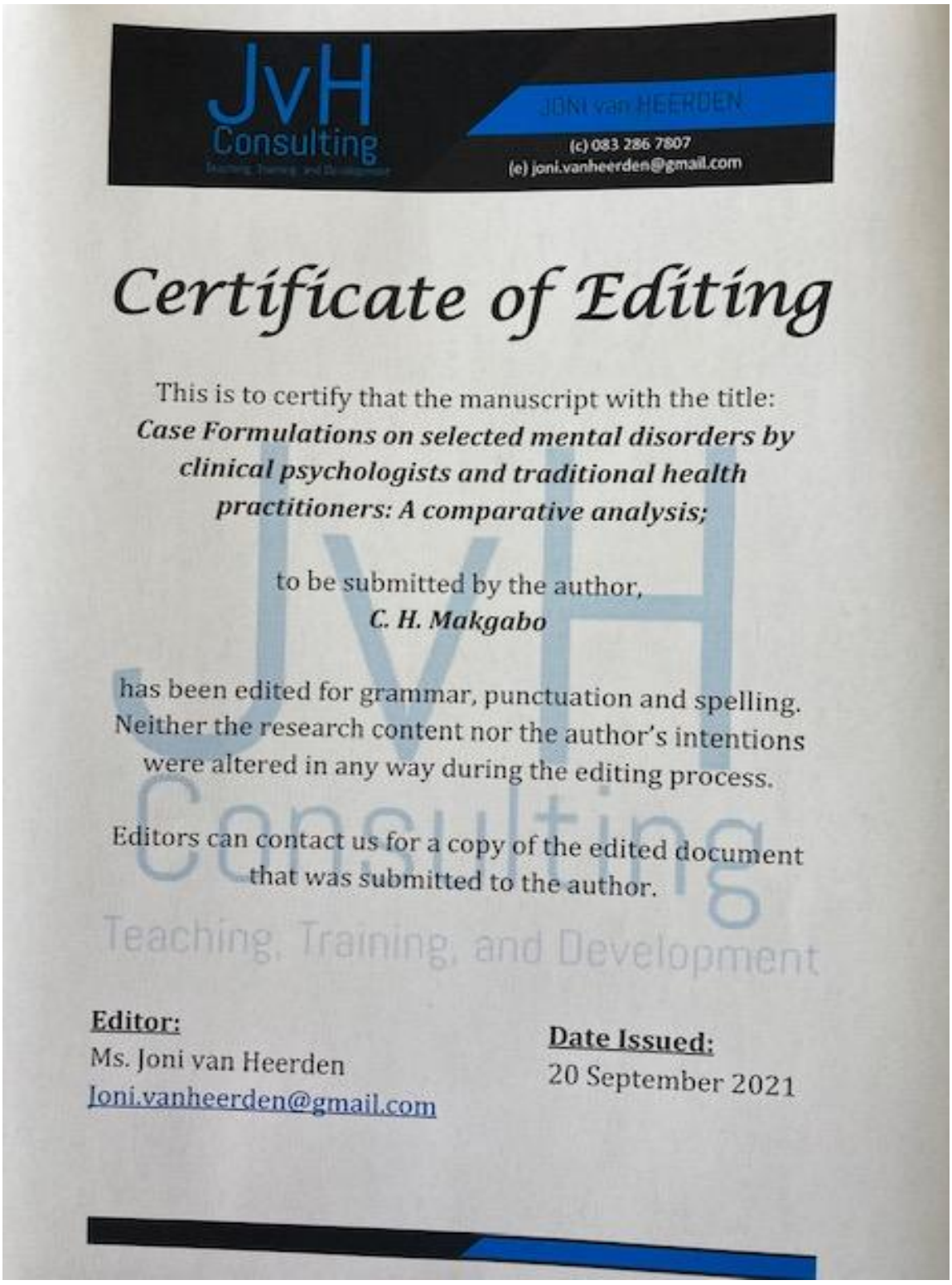
PROF P MASOKO
CHAIRPERSON: TURFLOOP RESEARCH ETHICS COMMITTEE

The Turfloop Research Ethics Committee (TREC) is registered with the National Health Research Ethics Council, Registration Number: **REC-0310111-031**

Note:
i) **This Ethics Clearance Certificate will be valid for one (1) year, as from the abovementioned date. Application for annual renewal (or annual review) need to be received by TREC one month before lapse of this period.**
ii) **Should any departure be contemplated from the research procedure as approved, the researcher(s) must re-submit the protocol to the committee, together with the Application for Amendment form.**
iii) **PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES.**

Finding solutions for Africa

Appendix 5: Certificate of editing



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Certificate of Editing

This is to certify that the manuscript with the title:
Case Formulations on selected mental disorders by clinical psychologists and traditional health practitioners: A comparative analysis;

to be submitted by the author,
C. H. Makgabo

has been edited for grammar, punctuation and spelling. Neither the research content nor the author's intentions were altered in any way during the editing process.

Editors can contact us for a copy of the edited document that was submitted to the author.

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