CONCEPTIONS OF ILLNESS, HELP SEEKING PATHWAYS AND ATTITUDES TOWARDS AN INTEGRATED HEALTH CARE SYSTEM: PERSPECTIVES FROM PSYCHOLOGICAL COUNSELLORS, TRADITIONAL HEALERS AND HEALTH CARE USERS

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DECLARATION

This is to declare that the work is the author's original work and that all the sources have been accurately reported and acknowledged, and that this document has not in its entirety or in part been submitted at any university in order to obtain an academic qualification.

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ABSTRACT

Perceptions of health and illness which include the perceived cause and recourse play an important role in diagnosis and management of illness. Traditional and allopathic medicines are used simultaneously and sometimes without the knowledge of the health professional and this has an impact on clinical outcomes. Overlooking patients' subjective experience, health providers' biases and prejudice may pose a negative impact on clinical outcomes. This study explores patients', traditional healers' and psychological counselors' perception of illness by conducting interviews and administering open-ended questionnaires. The data is analyzed both qualitatively and quantitatively through the use of content analysis and non-parametric statistical procedures. The results indicate that the concept of illness is complex and multidimensional with physical and socio-spiritual aspects. Effective management requires a joint approach between indigenous and western health systems. The results further show that traditional healers fully embrace the integrated health approach while there is some skepticism and uncertainty from psychological counselors which could be stemming from their training. There is still work to be done in terms of health planning and policy but also the training of health professionals.

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CHAPTER I: INTRODUCTION

1.1. Background to the Research

All societies have to respond to illness in the course of their development. Societies have long utilised their indigenous knowledges to formulate meaning around illness and also to find ways of managing illnesses. Perceptions about illness issues, such as diagnosis, cause and treatment are social constructs and thus reflect societal values and norms (Castillo, 1997; Kleinman, 2004; Swartz, 1998; Ryder, Yang & Heini, 2002). These norms and values differ across contexts because of differences in cultural assumptions about illness. Such contextual differences in norms and values have implications for the classification, diagnosis, and management of illness. This is particularly so for South Africans who are currently making efforts to create a context that recognises and shows sensitivity to African realities. For centuries, Western-derived constructs and ideologies of illness have dominated the health professions, while traditional African conceptions of illness were relegated to the margins (Marsella, 2003; Sam & Moreira, 2002; Castillo, 1997; Swartzz, 1998).

Before an integrated view of illness and illness management can be formulated, African beliefs and practices, which were previously not acknowledged, need to be made explicit. The indigenous perceptions of illness cannot be divorced from the understanding of the self in relation to its context. This then makes illness a medical, social and cultural construct (Castillo, 1997; Helman, 2000; Matsumoto, 2001; Ngubane, 1977). While the multi-dimensional view of illness is slowly being incorporated into mainstream practice, little has been documented about the rationale and ideology behind African perceptions on illness. African conceptions of illness, like any other tradition or belief, do not exist in a vacuum but change with acculturation, modernity, increased access to information and services, amongst other possibilities. Irrespective of the changes and Western influence, African indigenous conceptions of illness remain in use and need to be researched, explored and documented (Swartz, 1998).

Documenting marginalized conceptions of illness can help explain people's subjective experiences and interpretations of illness. This can yield important information that can be

used by health professionals to improve therapeutic alliance and clinical outcome, especially for illnesses where medical intervention has had limited success.

1. 2. Research Problem

This study investigates indigenous healers, western trained counselors and health care users' conceptions of illness, the perceived causes of illness and the resulting help seeking behaviours on the part of health care users. The study aims to gain insight into whether conceptions of illness become significant determinants of the type of health institutions that patients will seek help from as a result of their illness perceptions. It is therefore in light of this view that it becomes imperative to establish and bring to the fore, not only illness perceptions of service users but those of practitioners as well. The current study thus aims to determine the way forward in the treatment of illness by accessing the attitudes and perceptions of health professionals currently working within the proposed intergrated South African health care system. Gaining insight into such valuable knowledge could contribute to current understanding of local conceptions of illness, and the treatment implications thereof.

1. 3. Rationale

The management of illness and disease has been complex in the past but even more so now with icreased appreciation of the social nature of illness. It is plausible that this is due to the paucity of research into people's experiences of illness, including local theories of illness and the treatment thereof. While the international literature indicates fundamental differences in indigenous Asian and Western conceptions of illnesses such as depression (Castillo, 1997; Kleinman & Good, 1987; Matsumoto, 2001), there is a dearth of local studies investigating perceptions of illness among professionally trained psychological counsellors, traditional healers and health care users. This has major implications for the diagnosis and the treatment of illness. Moreover, the biomedical view of illness misses the subjective interpretation and experience of illness that is significant for the management thereof (Peterson, 2004). People do use traditional healing and allopathic medicine together and even simultaneously, but sometimes without the knowledge of their doctors. The implications of such are not known. The study aims to investigate the implications for clinical outcomes.

The increased availability of literature confirming these cultural and contextual differences in the interpretation and subjective experiences of illness creates a challenge to make local knowledge explicit (Castillo, 1997; Kleinman & Good, 1987; Jain & Agrawal, 2005; Kauchali, Rollins, Bland, & Van den Broek, 2004). It also calls for the documentation of oral traditional African cultural practices in order to reconstruct scientific theories that can be relevant and applicable to the South African context.

All cultures are confronted with major life challenges in the course of their development; this includes health-related challenges. Societies, using indigenous knowledge, have always derived means to manage illness. However, the complex nature of illness calls for an integrated approach that will create space for indigenous and western conceptions to co-exist without the one being more dominant than the other (Booi, 2005; Swartz, 1998). Before that stage however, conceptions of health and illness as well as attitudes of various health practitioners ought to be explored and made explicit.

1. 4. Methodology

The purpose of the study was to investigate perceptions and interpretations of illness held by professional psychological counsellors, traditional healers and health care users. This was done by investigating their conceptions, perceived causes and ways of treating illness. The study was conducted qualitatively, using a semi-structured questionnaire and in-depth interviews. The semi- structured questionnaire was used with the patients accessing western and indigenous health services (i.e. hospitals/ clinics and traditional healers respectively). Semi-structured questionnaires have been used in a number of similar studies across contexts (Bhui & Bhugra, 2001; Lloyd, 1996; Priebe, 2004). There was not a clear distinction between the data collection and the data analysis process. The questionnaires were analysed throughout the data collection process. This was done to modify, add or delete themes to increase the quality of the data. Where appropriate, data were also analysed using Statistical Package for Social Sciences (SPSS).

Individual interviews were used to gain an in-depth understanding of health providers' views of illness and the appropriate treatment thereof. A pre-drafted interview schedule was used to ensure that the core research questions were answered. The data were analysed

using the constant comparative method as described by Dye, Schatz, Rosenberg, and Coleman (2000). The research findings may have implications for the country's current conception of what the general public perceives to be illness and the treatment thereof. The methodology is reported in full in Chapter 3.

1.5. Aims and Objectives

The current study aims to investigate traditional healers, psychological counselors and patients' perspectives on illness. Further, the study aims to shed light to the possible relationship between conception of illness and help-seeking behaviours. The study also aims ascertain the views and attitudes of western-trained psychological counsellors and indigenous healers on the intergerated health system and cross referrals. Finally, the study intends to make recommendations for health planning, training and policy.

1.6. Research Questions

The study seeks to address the following questions:
a) What are patients', psychological counselors and traditional healers' perceptions and understandings of illness and the causes thereof?
b) How do western-trained psychological counsellors and traditional healers position themselves vis-à-vis western and indigenous views of illness?
c) What are health-service users' help-seeking pathways and what are the factors determining these pathways?
d) What are psychological counsellors' and indigenous healers' attitudes on integration and cross referrals?

1.7. Definition of Terms

Definitions adopted by researchers are often not uniform. Key and controversial terms are defined below to establish positions taken in this dissertation.

Ubuntu: refers to collectivity, communality, oneness, cooperation and sharing (Nefale & Van Dyk, 2003, cited in Solomon & Wane, 2005). It encompasses the African belief that humans become human through others. *Ubuntu* is inferred from the person's knowledge of

his or her duties and responsibilities within a community of other, interdependent human beings (Mkhize, 2003; Ngubane, 1977; Ramose, 1999).

Illness: is defined as the subjective experience of ailment or feeling of not being normal and healthy. Illness may, in fact, be due to a disease. However, it may also be due to a feeling of psychological or spiritual imbalance. Perceptions of illness are highly culture-related while disease usually is not (Boorse, 1975; Holdstock, 2000; O'Neil, 2006).

Disease: is a measurable pathological condition of the body caused by identifiable physical or chemical events (Boorse, 1975; O' Neil, 2006).

The ancestors: the ancestors comprise those deceased family members who observed high moral standards and for whom appropriate rituals of intergration (*ukubuyisa*) have been performed (Mkhize, 2003).

Ukubuyisa: is a ritual performed to "return" (hence *ukubuyisa),* the deceased from being "no where" (the 'wilderness' in Zulu Cosmology) to be integrated into family comprising the living members (Ngubane, 1977).

Ukufa kwabantu: refers to culture bound syndromes that are only prevalent in African societies. They are believed to originate from sorcery and as a result it is generally assumed that western doctors cannot understand or treat them (Ngubane, 1977).

Amafufunyane: is a type of mental state where an individual is believed to be possessed by spirits and will manifest symptoms such as mental derangement, hysteria, weeping uncontrollably, throwing oneself on the ground, tearing off clothing, and suicidal attempts (Ngubane, 1977).

Ukuqinisa: is to fortify or strengthen in order to prevent illness or disease (a traditional equivalent of vaccination against disease (Mkhize, 2003; Ngubane, 1977).

Social constructivism: is a belief that there is not true reality out there to be studied but the truth is socially constructed and these constructions are shaped by societal norms and values (Garrison, 2007).

Amadlozi or izinyanya: refers to the ancestral spirits, responsible for protection or disciplining the descendents (Holdstock, 2000; Mkhize, 2003).

Culture: is the system of shared beliefs, values, customs, behaviours, and artifacts that the members of society use to cope with their world. Culture influences people's perceptions of the world and their behaviour in it (Giddens, Mitchell, & Richard, 2003).

Patient: refers to the patient system, which includes the patient and the social network that is responsible for the sick individual.

Western: refers to the mainstream, mainly western idea of the self, namely individualism, where the focus or unit of analysis is the individual. Incorporated in the use of the terms 'western' in this study is the understanding that knowledge is value-free, objective and universal.

African: refers to anyone with African ancestry.

Psychological counsellors: in this study refers to psychologists, intern psychologists and professional psychological counsellors who have a psychological orientation to health care.

Traditional healers: refers to three categories of indigenous African healers namely *izangoma*, *abathandazi* and *izinyanga.*

Izangoma: refers to diviners who are normally consulted for diagnostic purposes. In some cases they do prescribe treatment.

Izinyanga: refers to indigenous "phamarcists" who prescribe treatment based on the diagnosis from *isangoma* or based on the presenting symptoms.

Abathandazi: refers to indigenous healers who rely on prayer and the ancestors for healing.

1. 8. Outline of the Dissertation

Chapter 1 situates the study within the body of relevant literature and by so doing demonstrates the gap in the field. Chapter 2 presents the literature and rationale for conducting the study as well as the research questions stemming from the identified gap. The methodology is discussed in Chapter 3; it presents the research design, the sampling techniques used to select the research participants, and a brief description of the different research instruments used to collect and analyze data. The results are presented and discussed in Chapter 4, while Chapter 5 provides the study conclusions, drawing out implications for theory, policy, practice and further research. The study limitations are briefly outlined.

CHAPTER II: LITERATURE REVIEW

2.1. Introduction

Self-concept influences psychological processes (Faulker, Faulker & Hesterberg, 2007; Kitayama, 2002; Markus & Kitayama, 1991; Shih, 1996). The self-concept itself emanates from the ontological assumptions of a culture that one is born into. The ontological assumptions dominant in a particular context will predispose an individual to a particular view of the self, depending on the cultural norms, philosophical assumptions, values and beliefs (Markus & Kitayama, 1991; Kitayama, Markus, Matsumoto & Narasakkunkit, 1997; Kitayama, Snibbax, Markus & Suzula, 2004). Differences in self-concept and culture play a pivotal role in the area of health and illness. Self-concept and culture firstly play a role at a national level as they influence health planning, government policies and the resources invested in the health sector. At a micro level, self-concept and culture play even a more significant role in shaping perceptions of illness, perceived cause, the help-seeking behaviours, the patient/clinician relationship and clinical outcomes (Lu, Lim & Mezzich, 1995; Shih, 1996). The literature provides a brief overview of the major differences in self-construction in traditional west and African societies. The implications of construals of the self on perception, diagnosis and treatment of illness are discussed.

2.2. Western Conception of 'Self'

Self-concept determines how we conduct our lives, how we come to terms with pain and what we are able to appropriate as our own experience (Ochberg, 1994, cited in Hyden, 1997). According to the traditional western perspective, the self is perceived to be independent and self-contained (Kitayama & Markus, 1991; Kitayama, *et al.*, 1997; Kitayama, Snibbe, Markus, Suzuki, 2004). Individuals are encouraged to engage with positive self-defining attributes such as self-actualisation, self-efficacy and self esteem (Kitayama *et al.,* 2004; Shih, 1996).

The primary focus is placed on the individual's happiness as well as the ability to individuate from others in order to develop one's own identity characterized by unique attributes. Culture and contextual factors are perceived to be secondary; they do not have as

much significant influence in shaping the self as believed in African and Asian cultures (Kitayama & Markus, 1991; Kitayama *et al*., 1997; Kitayama *et al*., 2004). For an example, in traditional western society, depression will be defined as a psychiatric syndrome characterized by specific affect, cognitive, behavioural and somatic symptoms (Kleinman & Good, 1987). Less emphasis is placed on cultural and contextual influences in the expression and interpretation of the illness. More emphasis is placed on the individual's internal processes such as cognition, emotion and behaviour.

In Asian societies, and the same could be argued for African societies in general, the self is perceived to be interdependent and embedded within its cultural context (Kitayama & Markus, 1991; Kitayama *et al*, 1997; Kitayama *et al*., 2004). Individuals are encouraged to adjust themselves to fit in with expectations of socially meaningful others (Morling, Kitayama & Miyatomoto, (2002), cited in Kitayama *et al*., 2004). For an example, a study between western and Japanese parents showed how Japanese parents encourage their children to be 'iiko', meaning good children characterized by diligence, docility and spirituality, whilst western parents encouraged self-improvement (Kitayama & Markus, 1991). The Japanese therefore worry over possible rejection namely, losing others' respect, approval and commitment.

Like in any society, western theories of illness are embedded in the western notion of the self. No theory is culture free; theories are byproducts of a specific context at a given time (Kitayama *et al*., 1997). Theories also reflect the cultural standards of what is believed to be normal and abnormal. Theories play an important role in the construction of diagnostic criteria and the treatment of illness. Moreover, they give tone to the therapeutic encounter.

2.2.1. Western Theories of illness

Western theories of illness have evolved over time, due to the complex nature of illness and new developments in the field. Some of the major western theories of illness include the biomedical, biopsychosocial and psychodynamic approaches. These approaches, although different, are shaped by the western concept of the self-contained, singular self.

Derived from the notion of an independent, self incorporating a clear distinction between mind and body (mind-body dualism), the biomedical approach assumes that illness is a

measurable pathological condition of the body caused by identifiable physical or chemical events (Boorse, 1975; O'Neil, 2006). Therefore, illness with no structural biological evidence is dismissed. Effective treatment changes the physical state of the body in such a way as to correct the physical cause of illness. For an example, depression will be diagnosed through biological indicators such as measurements of neurotransmitters, changes in brain chemistry and overall decrease in brain activity (Bland, 1997; Keller, 2003).

The biomedical approach, although very effective in diagnosing and treating the disease aspect of distress, ignores a large component of distress which is the illness aspect. The illness aspect of distress is mainly socially constructed; it sets the standard of what abnormality is, provides a script on the sick role, shapes the perceived cause of illness which then translates into help-seeking behaviours. Moreover, it predicts the efficacy of the therapeutic encounter. The biomedical approach is limited even when applied in western cultures because it neglects the subjective nature of illness and the cultural and contextual influences.

The failure of the biomedical approach to acknowledge the embeddedness of culture, self and illness led to the development of the biopsychosocial approach to illness (White, 2005). The biopschosocial approach is based on systems theory, which agrees with the view that the self is vulnerable to sociocultural and psychological influences. It further acknowledges the role played by life experience and current social situations in the presentation of illness. Treatment interventions target the person and not the disease. The biopsychosocial approach therefore stresses the importance of a holistic and intergrated approach to the management of illness (Malmgren, 2005, cited from White, 2005). For example, the approach is more effective in psychosomatic disorders where biological and neurological instruments cannot diagnose the illness. The focus would be on identifying any psychological and social factors causing the vulnerability of the body.

The biopsychosocial model promises a comprehensive approach to the treatment of illness as it encourages multidimensional interventions that view individuals as embedded in their context (Deep, 1999; Pilgrims, 2002). Its cross-cutural effectiveness is however limited because it does not challenge the construct validity of illness. While the biopsychosocial model of illness acknowledges social and psychological influences shaping the subjective

experience and treatment options, it fails to mention that the standards of abnormality will differ across contexts. For an example, what is conceived to be illness in one context might be considered normal in another context. Moreover, although the model acknowledges the relationship between body and mind, it fails to account for the specific cognitive processes that will impact on physical illness (Malmgen, 1995, cited in White, 2005).

The concept of illness has also been considered from a social constructionist approach. Social constructionism is based on the assumption that there is no truth 'out-there' but what is perceived to be truth is a social consensus and reflects social norms of a particular context at a given time. Constructs such as illness and self are social in nature; they are linked to societal norms, values, socio-economic and political factors (Chakavati, cited in Kelly & Lewis, 1987; Cooper & Denner, 1988; Marks, Murray, Evans & Willig, 2000). Illness and self will therefore differ across context and culture and will be based on the cultural and contextual standards of abnormality. For an example, in some African communities, minor mental illnesses such as anxiety and phobias are not necessarily regarded as illnesses. Although individuals might experience the symptoms, often they are not treated because in these contexts they are not perceived to be pathological. It has only been with the increased exposure to western influence that more and more people seek help for these illnesses. Moreover, according to social constructionism, health and illness are perceived to exist as extremes on a continuum because neither is purely ideal-typical when it is located in reality.

Social constructionism assumes that, while discourse constructs different versions of reality, the material world cannot accommodate all constructions equally well. Some discourses are more dominant than others and they are taken as the only 'true' reality. Western notions of illness and the self have dominated and have often been assumed to be 'the' reality. This has meant that alternative indigenous ideologies have been overlooked or downplayed and not adequately supported as a result. In South Africa it has only been post the apartheid era that such knowledge has increasingly been given the attention it deserves and a lot of resources have been invested to alternative health systems. For an example, many studies have investigated the number of Asian and African people accessing western health institutions and conclusions have been drawn about the prevalence of mental illness in those societies, based on the number of cases seen in western institutions. This overlooks

the fact that a large portion of these communities probally access services of traditional indigenous healers for these illnesses.

It is problematic when one set of reality is taken as the absolute truth thus undermining and overlooking alternative explanations. This has negative implications for the diagnosis and the treatment of illness. This has been the case in South Africa's sad past, where traditional African views were marginalized by dominant western conceptions. Government and training institutions did not promote or make such knowledge known, as they did with Western approaches to knowledge. Irrespective of the little emphasis placed on traditional African worldviews, people at the community level subscribe to such beliefs and access the service of traditional healers and often secretively (Booi, 2005; Holdstock, 2000; Swartzz, 2002). Unpacking these realities is important for the transitional stage at which the country is in. This will ensure a comprehensive approach that will effectively manage the physical and spiritual aspects of illness while possibly increasing access to health care.

To summarize, there are major advances that have been made in the field of health and illness using western approaches, even across contexts and cultures. There have been major psychological and medical breakthroughs in the treatment of illness. A number of diseases such as diabetes and depression can be successfully managed using these models. With the passage of time, these models have realized the complexity of the concept of illness and the treatment thereof and as a result have attempted to incorporate cultural differences in order to provide a comprehensive view of illness.

Although the theories presented above differ, they are all based on the western concept of the self; they are congruent to the context and culture from which they were constructed. They are all based on the assumption that illness is internal to the person, whether caused by organic or complex anxieties or destructive learned behaviour (Lu, Lim & Mezzich, 1995). The theories become more problematic when they are used and imposed uncritically across cultures and contexts. Furthermore, it is problematic when one set of reality is taken as the absolute truth, thus undermining alternative explanation of illness. This creates an opportunity for misdiagnosis, and incorrect treatment and poor therapeutic outcomes. This section below shows how western theories of self and illness impact on diagnosis, treatment and help-seeking pathways.

2.2.2. Self and its Influence on Diagnosis

It has been established that culture, illness and the concept of the self have an intricate relationship with each other. While diagnostic manuals are often perceived to be value free and neutral, they are social constructs and as such reflect norms and standards of normality of a particular context and at a certain time (Faulker, Faulker & Hesterberg, 2007; Lewis, Fernandez & Diaz, 2002). Due to their social and subjective nature, these manuals hold potential for misdiagnosis, which will translate to ineffective treatment intervention, especially across contexts. The DSMIV TR (APA, 2004) acknowledges the cultural embeddedness of illness and the self and has attempted to make adjustments to include culture-bound syndromes and the cultural formulation framework that will be specific to certain contexts and cultures. Although strides have been made to incorparate cultural factors into the DSM, diagnosis is still largely dependent on the individual's ability to articulate his/her symptoms; the same categories are used to classify illness. There is not much work done in investigating and developing more categories of illness that are relevant to other contexts. The construct validity of existing psychological constructs is not questioned or challenged.

In line with the traditional western notion of an independent, self actualized and self-reliant self, mainstream western approaches to illness locate the cause of illness internally, within the person. The diagnosis is aimed at identifying the symptoms for potential classification and treatment. The focus is on symptoms, whilst in African cosmology the diagnosis focuses on the person as a whole, including his/her context (Ngubane, 1977). For example, someone may present with a swollen leg; the diagnosis could be that the ancestors are not pleased about a certain issue in the person's life or the person might be diagnosed with *umeqo* (i.e. of having stepped over harmful concotion). The focus is not primarily on the swollen leg but why is the leg swollen. While treating or repairing the swollen leg which is often embedded in broken relationships will alleviate the symptoms, it does not address ideological concerns such as why is the leg swollen at this point in time. The diagnosis is based on the African belief of an interdependent self that finds its existence through others and that broken relationships cause illness. Meanwhile, in traditional western societies the

diagnosis is primarily biological, neurological or psychological. This explains why treatment options are often targeted at the individual.

Moreover, diagnostic manuals such as the DSM are based on the notion of an individualistic and self-actualized self that is assertive and able to express itself adequately for the clinician to make a diagnosis. Thus, it is generally assumed that illness will be expressed in individualistic, intrapsychic terms or in relation to factors that reside within the person. This is what Castillo (1997) refers to as the idiom of distress. Idioms of distress are linked to cultural norms and values (Castillo, 1997; Matsumoto, 2001). This includes the non-verbal cues that form an important part of the diagnosis. For example, in some cultures avoiding eye contact is perceived to be a sign of respect. In other contexts, however, this could be a significant clinical indicator for diagnosis of pathology.

Another misconception assumed in diagnostic manuals is that people across cultures and contexts will use the same vocabulary to explain their subjective distress. Research shows otherwise. For an example, the words used to refer to depression range from sunken heart, tiredness, nerves, thinking too much, hypertension and frustrated ambition (Kleinman & Good, 1987; Patel, 2001). The different idioms of distress may lead to misdiagnosis, over-diagnosis or under-diagnosis. For example, a study conducted by Ying (1988) among the Chinese showed that very few reported the standard psychological symptoms of depression, such as irritation, rumination and poor memory. The majority reported physical symptoms and was misdiagnosed with somatization disorder.

Western approaches to diagnosis are effective in their own right, especially when they are used in the context in which they were constructed. While they have also been used with some level of success across different contexts, cultural limitations have been reported as far as effective and accurate cross-cultural diagnosis is concerned. Lewis-Fernandez and Diaz (2002) recommend that clinicians should go beyond the diagnostic manuals and consider the patients' explanatory model of their distress as well as alternative explanations to ensure accurate diagnosis. Clinicians should be able to explore these alternative explanations with their patients, especially because research has shown that people will access both western and traditional health services (Swartzz, 2002). Misdiagnoses often result from the cultural incompetence of the clinician (Lu, Lim & Mezzich, 1995;

Neighbors; n.d.). Accurate diagnosis is important for effective treatment, heath policy and planning and service delivery (Neighbors, n.d.).

2.2.3. Self and its Influence on Treatment

Treatment options, like diagnosis, are not immune to cultural influences. It is often assumed that clinicians prescribe treatment that is in the best interest of the client and that clinicians will suspend their subjective judgment and biases when treating their clients. Often, treatment will be based on diagnosis. In the current literature, it has been established that diagnosis and ultimately treatment are never value free; they reflect the norms and beliefs of a particular context about the nature of illness. For an example, Sam and Moreira (2002) illustrate how a person presenting with depressive symptoms is treated differently in different cultures. In western cultures he is treated by a psychiatrist using anti-depressants while in Africa he is sent to a traditional healer who will identifies problems in the realm of relationship and hence treatment is geared to mending broken relationships.

In making decisions about the treatment plan, the clinician has to decide which individual in the patient system will be the index patient. Determining the index patient is embedded within cultural beliefs about the self and its relationship with its context. In traditional western society, the individual is perceived to be independent and responsible for his or her own health decisions. Interventions therefore are targeted at helping individuals readjust to the changes in their life. For an example an individual presenting with depression following a death of a parent could be treated with depressive medication and individual therapy. This is congruent with the western traditional notion of the self. In traditional African contexts, the treatment of illness will not just involve the patient; it may incorporate the entire family- living and deceased (ancestors).

These views have implications for policy, health education and the efficacy of health outcomes. The holistic approach, which involves locating the illness in the system and not within the individual, has potential for minimizing stigma and allowing for the reintegration of the ‘sick’ individual back into the community. The community takes ownership and this ensures adequate support for the sick individual. On the other hand, it may perpetuate or encourage a situation where individuals do not take responsibility for

their own health. This is especially so in a context like South Africa with the AIDS pandemic, where assuming responsibility is crucial inspite of the social, economic, cultural and political factors fueling the pandemic.

The situation is much more complex when the patient and clinician have different views about appropriate treatment. Disagreements about the right diagnosis and the treatment proposed will negatively impact on the patients' compliance with treatment (Castillo, 1997; Van Voorhees, Fogel, Houston, Cooper, Wang, & Ford, 2005). Defaulting on medication may have serious implications. The situation becomes further complicated when there is no communication between the clinician and patient about the recommended treatment and alternative medication the patient might be taking for the same symptoms. For example, the simultaneous use of allopathic and traditional African medication has been noted amongst many African patients. Open communication about the client's explanatory model could possibly strengthen the therapeutic alliance (Berg, 2003).

2.2.4. Western Concept of Self and its influence on Help-seeking Pathways

Help-seeking pathways include the remedial steps that an individual assumes to restore health. Help-seeking pathways are based on the subjective interpretation and the meaning attributed to the symptoms (Castillo, 1997; McKain, 2003). They also include learnt behaviours of how to deal with the symptoms. Help-seeking behaviours will therefore differ across contexts and cultures (Castillo, 1997; Faulker, Faulker & Hesterberg, 2007; Lim & Lu, 2005; Lu, Lim, Mezzich, 1995). For an example, in traditional western society, help-seeking pathways are simple, limited and predictable because of their cultural interpretation of illness. Often, individuals assume responsibility for their own health and will individually consult western health institutions. There is less consultation within the family, which increases the likelihood of symptoms being managed early. The trend seems to be changing as more western individuals are accessing alternative health systems such as homeopathy (Kaptchuk, David, & Eisenberg, 1998). This is because cultural norms are fluid and change with environmental changes.

In non-western contexts, help-seeking pathways are complex; they involve negotiations between the patients and their social network about the appropriate treatment, depending on the perceived cause. Due to the complex nature of how illness is perceived, help-seeking

pathways are not predictable and linear; they may include back and forward movement between western and traditional health care systems. For an example, studies done in South Africa show how African people will simultaneously access the services of western and traditional healers for same symptoms based on the cultural conception that illness is both physical and spiritual. These services are used to compliment each other (Berg, 2003; Swartzz, 2001). The issue will be explored in depth later in the chapter.

The differences between predominantly western cultures and predominantly African traditional cultures indicate that no one help-seeking pathway is better than the other; both reflect the cultural interpretation of the distress. It is thus important to accommodate both realities for illness to be managed effectively.

The current study acknowledges that, although these are dominant traditional western and African views, there are however individual, familial and contextual variations. Self-concept has implications for health and illness both at micro and macro levels. It further shapes health planning, the health services that receive government funding and training offered to health professionals. At a micro level, it will shape the therapeutic encounter between patient and clinician, as well as the diagnosis and interventions recommended.

On the other hand, there is a scope for understanding indigenous conceptions of illness. There is a need for making indigenous voices heard and also incorporated into the health care system for better management and treatment of illness. What western models fail to do is to highlight subjective meanings and understandings of illness and the implications thereof. Most western models come with ready-made constructs, which are then imposed on local populations; as a result, indigenous knowledge and belief systems are marginalized. The study acknowledges that it is not realistic to expect that all clinicians will have in-depth knowledge of all cultures or treat people from their cultural background but it is ethical that each clinician should be culturally competent. Cultural competence includes taking into cognizance patients' explanatory models, which include their perceived causes of illness, help-seeking pathways and their cultural standards of normality and abnormality, without losing sight of cultural prejudices and misappropriation of beliefs (Lim, Lu & Mezzich, 1995). Moreover, the argument is not that one view of self is better but the aim is to raise awareness about the differences that exist across contexts and cultures and the potential impact on illness.

Recent research in medicinal plants has shown the tremendous potential that indigenous knowledge has in the treatment of illness (Van Wyk, Van Oudtshoonrn & Gericke, 1997). Furthermore, looking at the other, less dominant voices gives acknowledgement to alternative treatment options.

Although western conceptions of illness, treatment and prevention have evolved and improved, questions remain about their ability to accommodate alternative explanations outside western conceptions. Traditional African conceptions are comprehensive; they do not preclude biomedical or western-based conceptions, thus allowing for a holistic approach to illness management.

2.3. Indigenous Conceptions of Illness

Illness, according to an indigenous African perspective, is complex and multifaceted. It incorporates religion, spirituality, and kinship, biological and socio-ecological influences. The African conception of illness is based on African ideologies of the self as a relational self, which is captured by the African saying "I am because we are or "*umuntu ngumuntu ngabantu,*" meaning not just people who are living but inclusive of spiritual beings in the form of ancestors and God. The ideology of the self plays a significant role in how life is viewed, interpreted and experienced. The following section presents a brief overview of the relational view of the self, commonly found among African societies, amongst others. The section also highlights the metaphysical ontology on which this view of the self is premised.

2.3.1. The Self: An African Perspective

Understanding the self from an African perspective helps explain how illness is perceived and treated in the traditional African context. In traditional African thought, the self is never perceived as an independent entity, striving for autonomy and self-actualization. Rather, the self exists among other living and non-living entities, constituting a hierarchy of beings. At the top of the hierarchy is the Supreme Being, God or *Umvelinqangi.* Below God are the ancestors or *izinyanya*, and then the community of the living and then the animals followed by non-living objects. Life always entails the interaction and maintenance

of harmony between the different levels of being. Harmony is indexed by supportive relationships within family, the community, the cosmology and with God *(UMvelinqangi or uNkulunkulu)* and ancestors (*izinyanya or amadlozi)*. It is through these relationships that the self is defined. This view of the self plays an important role in traditional African conceptions of health and illness (Booi, 2003; Ngubane, 1977).

Nwoye (2006) describes the African self as in direct constrast to western notion of the self. In an African view, the self is inclusive and extensive acknowledging the important of the physical body. The focus is not soley on inner individual believes as in western notions but the emphasis is how the self projects itself onto other realms of human existence i.e. social, economic, religious, political and cultural (Chabal & Daloz, 2006 cited in Nwoye, 2006). This is what is termed as the communal self which is relational, dialogical and inclusive of others. There is a mutual dependence of selves in the world of the living and the living-dead. So man is not just an individual or just social being but a vital force that interacts with other forces (Holstock, 2000).

The sense of self is captured by the African saying *"umuntu ngubuntu ngabantu*" meaning one finds his true sense of self and identify and meaning through participation with the community of others (Nussbaum, n.d.; Holdstock, 2000). Grills (2004, cited in Jones, 2004) and Ogbonnaya (1994) further mention that to be human is to belong to a community and the community in turn is represented in the individual. Community refers physical emboied humans and the community of the living dead. For effective living and fulfillment one is continuesly moving and adjusting to the changes in the community to maintain state of equillibrum and harmony (Ogbonnaya, 1994; Phillips, 1990). This does not rule out sense of individual sense of self but it also encompasses being cognizance of the needs to others whilst attending to own needs.

The next section aims to give a voice to the traditional African conception of illness and illustrates the comprehensive and multidimensional nature of traditional conceptions of illness. Possible implications for diagnosis and treatment of illness are also considered.

2.3.2. Indigenous Conceptions of Health and Illness

Health, according to traditional African conceptions, is a state of equilibrium between the different levels of being, ranging from God, the world of ancestors, the community and the environment. Failure to take responsibility in the family and failure to appease the ancestors destroy the relationship and destabilizes the equilibrium. Broken relationships (disharmony) may ultimately cause illness (Bojuwoye, 2005; Melato, 2000; Ngubane, 1977). For an example, a study conducted by Gureje, Lasebikan and Oluwanga (2005) on a Yoruba-speaking Nigerian sample, indicate how mental illness is mainly attributed to evil spirits, which signal the discordance between the individual or the family with particular members of the community. Only one in ten respondents mentioned biological factors, trauma or stress as potential causes of mental illness. Nine (9) percent of the participants further felt that mental illness was a form of punishment from God and six (6) percent perceived poverty to be the major cause of illness. While this strong perceived spiritual nature of mental illness could be a result of participants' poor knowledge of western-classified categories of mental illness, it is possible that it is also attributable to different conception of illness; a conception that does not draw sharp boundaries between the material and spiritual worlds. When people use the term 'mental illness', it is mainly associated with major psychotic episodes (Sow, 1978). The results might not be reflective of 'minor' mental illnesses.

Health is not only perceived as the absence of disease; it also involves the individual's ability to function within his/her social context whilst a breakdown in social relations creates vulnerability to illness. Maintaining a balance between the mental, physical, familial /social, and spiritual realms ensures good health. Health is therefore a state of complete well being based on a way of living, good conduct and good relations with others and a unity of body and spirit (Garro, 2000).

Illness is conceptualized holistically, incorporating dimensions such as the physical, social and spiritual components. For the purpose of this review one dimension at a time will be discussed. In the African conception dimensions are interrelated and do not exist in isolation of each other.

2.3.2.1. Dimensions of Illness

This section reviews the different components that shape indigenous African perceptions of illness. A brief description of each aspect is given and then implications for diagnosis and treatment are discussed. Components discussed include relational/spiritual and biological aspect of illness.

2.3.2.1.1. Socio-spiritual aspects of illness in indigenous thought

Social relationships, according to the African conception of illness, are perceived to be central in the diagnosis, etiology and treatment of disease and illness. Illness is the failure of complex social and spiritual relationships (Hillenbrand, 2006). This does not only include social relationships, it extends to relationships with spiritual family or family members that have passed away. For example, if an individual fails to fulfill the wishes of a deceased parent, that creates internal turmoil or conflict, which may cause illness, or a series of bad luck. Moreover, not performing the required rituals for a deceased family member creates discordance in the spiritual realms, which may in turn cause illness. Treatment is sought to restore the discordance that might exist in the physical or spiritual realm. A study conducted by Gureje, *et. al*. (2005) on Nigerian sample shows that although the sample believed in biological and natural causes, the emphasis is on the spiritual causes of mental illness. Ngubane (1977) and Bojuwoye (2005) draw similar conclusions.

Illness further serves as a tool for the ancestors to communicate or convey a message to the living (Hewson, 1998; Melato, 2000). The message is mainly that of dissatisfaction because of bad relations between family members or between the ancestors themselves and the family. Ancestors, '*amadlozi'* or '*abantu abadala*,' as usually referred to in African families, are the anchors of the family, not withstanding variations amongst households. The term '*abantu abadala'* can be directly translated to mean elders and the family's relationship to the ancestors as such (Holdstock, 2000). The elders need to be informed of any occasion or event occurring in the family. Often, this serves as a plea for their blessing. Failure to acknowledge one's ancestors by offering them libations may cause illness.

Discordance between the living and the ancestors may manifest through illness of a child or a family member, among other possibilities (Ngubane, 1977). For example, when a child is sick, often the sickness might be caused by the ancestral unhappiness about a particular issue in the family, which does not directly involve the child, such as a failure to perform a cleansing ceremony or forgoing the process of *ukubuyisa*.

Illness, therefore, may serve as a reminder to the family of their dependence on the ancestors to buffer them against any type of illness. To preserve good health, people will therefore align themselves with the wishes of the ancestors (Reynold, 1997). People will therefore engage in cultural rituals such as *ukuhlaba* (ritual offering) to appease the ancestors and maintain their favour through the assistance of traditional healers.

Illnesses that are often referred to as ukufa kwabantu are considered to be *caused* by manipulation of earthly elements. *Ukufa kwabantu* relates to different types of illnesses, both physical and psychological, that befall an individual after an enemy has manipulated earthly elements to bring sickness or misfortunes (Ngubane, 1977). This category of illness may include types of illnesses that have mystical origins such as *isinyama,* which is a form of pollution that is brought onto the individual through the practice of witchcraft. To buffer against such pollution the individual would need a traditional form of immunization, which could be carried out by the traditional healers through the ritual of *ukuqiniswa* (to strengthen the individual in order to prevent susceptibility to illness).

The other dimension of illness is the biological, which, together with the relational dimension, forms the comprehensive and multi-dimensional traditional African conception of illness.

2.3.2.1.2. Biological Aspects of illness in indigenous thought

The traditional African view acknowledges natural or biological sources of illness (Melato, 2000; Ngubane, 1977; Bojuwoye, 2005). This is what is termed *umkhuhlane*. Illnesses with a biological origin may be due to life stressors or the process of aging (Friedman, 1998, cited in Melato, 2000; Mafale, 1997, cited in Melato, 2000). Examples of such illnesses include mental retardation, epilepsy, genetic disorders, and schizophrenia. These

types of illnesses are not exclusive to Africans because people from other settings would have knowledge of them (Ngubane, 1977). As a result, both *izangoma/izinyanga* and western trained professionals can treat such illnesses. For an example, a study on maternal perception of their children's respiratory disease, conducted by Kauchali, Rollins, Bland and Van den Broek (2004) in KwaHlabisa in KwaZulu-Natal, showed that respiratory disease was attributed to natural causes (i.e. illnesses that 'just happen', caused by 'germs', 'cold weather', and the like).

2.3.3. Implications for Diagnosis and Treatment

At the core of African approaches is the idea that illness results from a breakdown in interpersonal, familial and communal relationships. The African conception of illness allows for multiple causalities, which incorporates biological, psychological, social, ecological and spiritual dimensions (i.e. illness as a failure of social and spiritual relationships). In terms of treatment, mending the relationships is considered more important than the treatment of the body *per se*, such that even if one has been healed physically, it remains important to discover the 'primary root' (socio-spiritual) cause of the illness. Such an approach to illness ensures a holistic management of illness, as it recognizes both the physical and the socio-spiritual nature of illness. For an example, a study on traditional African healing, conducted by Hewson (1998), shows how traditional healers as part of the diagnostic process will determine the nature of the illness by directly focusing on the symptoms and through questioning will reveal the illness in context in social and environment dimensions of a person's life. This is done with the belief that people are products of their contexts and as such past and present events impact on their health. The traditional healer does this by asking the patients question such as "is there someone that you are in-conflict with?" and "are your ancestors not pleased with you?" etc.

According to the African conception of illness, diagnosis is then first aimed at identifying the root cause of the distress. The African conception holds potential not only to provide holistic treatment for the index patient, it also facilitates involvement of the family and the community where the client is located. For an example, to mend the relationship, the client might be required to perform *umsebenzi,* which is a social gathering where certain rituals are performed and both the family and the community are invited to share the slaughtered animal which was sacrificed to appease or ask for forgiveness from the ancestors.

Moreover, the social system, be it the family or community, is required to change to accommodate the index patient, thus minimizing stigma and discrimination against the client. Such changes could include improvement in interpersonal relationships among family members or accepting responsibility for the illness as a unit. This is important for prevention of relapse and effective management of illness. However, communal acceptance of responsibility and the emphasis on socio-spiritual aspects may lead to individuals not taking responsibility for their own health and could perpetuate health risk behaviours.

Although African conceptions of illness seem to be an integrated way of looking at disease, there are concerns regarding the conflicting messages that might be communicated by traditional and western type healers when treating the same symptoms (Swartz, 2000). At the same time, it is known that people from African societies have been using the services of both western trained professionals and traditional healers. For an example, a study conducted by Osagie (2002) on a Nigerian sample shows that people from African societies simultaneously sought the services of traditional and western- trained professionals for the treatment of illness. Western-trained professionals are consulted mainly for the management of the symptoms while traditional healers are consulted for understanding the underlying cause of the symptoms. Communities have established a harmonious way to merge the two and little is known about the implications of this. One cannot assume that the simultaneous use of traditional and western medicine has led to holistic management of illness. The effect of simultaneous use of traditional and western healers is not well researched; the simultaneous use of the African potato (Hypoxis hemercallidea) and anti-retroviral drugs can potentially inhibit ARV drug metabolism and transport (Langlois-Klassen, Kipp, Jhangri & Rubaale, 2007). This mainly occurs when the two medications are taken in secrecy and not communicated to the health professional and caution is not taken. The secret use of these medications is perpetuated by the lack of trust and suspicion of the other health service providers. Hillenbrand (2006) mentions that the simultaneous use of traditional and western services by patients calls for improved dialogue between practitioners.

In addition, not taking away the effectiveness oftraditional healing, especially in societies that are communallyoriented, there have been a number of instances where people have not received the best possible treatment because the sector of traditional healing in South Africa is not strictly regulated. On the other hand, one has to acknowledge that, with the

preponderance of illness and the demands it places on the health system, there are some areas where traditional healing methods have proved to be ineffective. For an example, the symptoms of sugar diabetes are similar to the symptoms of *umeqo* but treating diabetes with the methods used to treat *umeqo,* such as *ukugcaba,* that is, cutting a person using a razor and applying *intelezi* over the wound, might prove detrimental to the diabetic's condition. In the case of diabetes, the wound might become septic and never heal and that could endanger the individual. A study conducted on Cameroonian traditional healers showed that traditional healers readily accept their limitations and are willing to work with western trained professionals to improve their services (Hillenbrand, 2006).

There are also aspects of the African conception that are mostly culture-specific and would be problematic when applied across cultures and contexts. One type of such syndrome is the *ukuthwasa 'illness',* which is characterized by 'hallucinations', aggressive and irrational behaviour. *Ukuthwasa* could be mistaken a psychotic episode due to the nature of its symptoms. However, *ukuthwasa* is understood to be the sign of a calling to become a traditional healer. There is a fine line between the two; making a correct diagnosis requires in-depth knowledge of both African and Western approaches to illness (Gumede, 1990 cited in Melato, 2000). The recent emergence of Western (white) *izangoma,* trained in traditional African healing, further complicates this, making the *ukuthwasa* category not exclusively for people from African cultures. So, to conceptualize a South African conception of illness will require renegotiations between indigenous and western trained professionals on diagnostic criteria and the re-training of health professionals. The frictions and sometimes the similarities between Western and indigenous knowledges highlight the need for new theories and conceptions of health and illness in order to reflect the South African reality on the ground.

This section of the literature review has covered African approaches to illness, the aim being to demonstrate that the African view can exist harmoniously with the western conception of illness and can also be used to cater for the spiritual aspect of illness that is ignored by traditional western conceptions. This has implications for help-seeking behaviours.

2.3.4. Help Seeking Behaviours

This section looks at what informs traditional African help-seeking behaviours. It also explores the decision-making processes as with regard to treatment options. Furthermore, the section aims to demonstrate how conceptions and perceived causes of illness influence decisions regarding the appropriate steps to take in dealing with distress.

MacKain (2003) highlights an important aspect in the conception of illness and the treatment thereof, namely help-seeking pathways. The term refers to a sequence of remedial actions taken to rectify perceived ill health. Rogler, Dharma and Cortes (1993) further mention that people's help seeking pathways are not individualistic, i.e., they are not only based on the distressed person's effort and that of his/her significant others, but also include both formal and informal institutions such as the family and health institutions. Freidson (cited in Rogler, Dharma & Cortes, 1993) explains the process of help seeking behaviour as involving an interpersonal encounter between the person who is distressed and his/her significant other. Consultation starts with the intimate nuclear family and then extends out of the home until it reaches the health professional or far and distant people (Versola-Russo, 2004; Vontress, 2000). For an example, a study conducted by Crawford and Lipsedge (2004) on a Zulu sample highlighted the consultative nature of help-seeking behaviours. The major disadvantage of the consultative nature of illness in collective societies especially is that the networks have a stronger interconnectedness among themselves and much larger social support, which then decreases the number of people accessing health facilities and delays treatment (Rogler *et al*., 1993). This is in inspite of the importance of social support in the rehabilitation and management of illness.

MacKain (2003) further suggests that people's help seeking pathways have not been understood: it is often believed that spreading information about the causes of illness will direct peoples help seeking pathways and change behaviour. He however believes that people's help seeking pathways are very complex and do not solely lie with the individual but are influenced by socio-economic variables such as gender, age, the type of illness, access to services and the perceived quality of the services provided. People's decisions about their health are made in the context of their daily social and culturally-embedded lives. Based on their cultural belief systems, people will often use different pathways for different types of illnesses, which then may impact on the duration of the symptoms. Using

a hypothetical case, Castillo (1997) shows how a man presenting with similar symptoms consults different health practitioners ranging from shamaan, priest, *isangoma* to a psychiatrist, depending on the economic, socio-spiritual and political factors of a particular context. A similar observation is made by Swartzz (2000) on a South African context. Africans will routinely consult traditional healers after hospitalization because of the African view of the dual nature of illness. Whether such treatment is complementary still needs to be investigated but people consult the different sectors because of the belief that they target different aspect of the illness. Bedri's (2001 cited in MacKain, 2003) study on the Sudanese sample, concludes that people's help seeking behaviour is a process and when help-seeking behaviour is delayed, it may be detrimental to life.

Due to the social nature of illness and help-seeking pathways, gender will therefore have an impact on the reaction to illness.

2.3.5. Gender Differences in Help-seeking Behaviours

There are gender differences in the utilization of health services. In a Kenyan study on HIV/AIDS and help-seeking behaviours, males were more likely than females to seek medical assistance. Thirty-five percent of the women were less likely to seek help because the symptoms were not considered severe and symptoms disappeared with time. Treatment was delayed because of financial constrains (Voeten, O'Hara, Otido, Habbema, Ndinya-Anchola, Bwayo, 2003). Similarly, Smith, Braunack-Mayer and Wittert (2006) mention that generally there are gender differences in help seeking behaviours. Such factors include adherence to patriarchal masculine characteristics such as superiority, independence, self-reliance and dominance. On the contrary, in a study conducted in Northern KwaZulu-Natal, there were no gender differences in help-seeking behaviours. Differences in help-seeking behaviours differed according to age, length of sickness, educational level, and asset ownership (Case, Menendez, & Ardington, 2005). The results from Northern KwaZulu-Natal showed that both increased access to western health services and the duration of the symptoms were significant determinants of help-seeking pathways. Western services were not used to supplement the roles of traditional healers but both services were seen as complementary (Case *et al.*, 2005). Illness is both a biomedical and spiritual phenomenon and as a result traditional healers are consulted to explain the meaning of the disease for that particular person (MacKain, 2003). Rogler, Dharma and Cortes (1993) argue that the

majority of pathways of distressed persons do not lead to the involvement of health professionals because people often self-medicate. Modernization does not necessarily lead to a shift from traditional health institutions to Western medical services (McMiller & Weisz, 1996).

People's help seeking pathways do not follow a predictable route. MacKain (2003) argues that help-seeking behaviour varies for the same individual depending on cultural beliefs and the type of illness. There may also be variations within the same culture and for a single individual depending on the merits of each case. Rogler *et al*. (1993) argue that it is culture that mediates the individual's subjective experience of the distress. In addition, culture then informs people's choices about the mode of treatment or inhibits actions towards seeking help.

The literature presents a traditional African view that may not exist in its purest form because of cultural exchange, increased health services and the effect of modernization. Some Africans, because of these influences, no longer subscribe to pure traditional views and this has implications for the diagnosis and the management of illness especially in South Africa.

2.3.6. Acculturation, Modernization and Help-seeking Behaviour

Solomon and Wane (2005) argue that acculturation has not led to a fundamental shift in people's beliefs in traditional healing. People are more likely to use both Western and traditional health systems. There are many debates regarding when people choose one method over the other. Research shows that people's choices depend on the type of illness and the perceived cause of the illness. It also depends on people's preferences because people are becoming more autonomous and often subjected to the influence of Western religious beliefs, which often discourage the role played by ancestors in African societies. People will usually use traditional healing methods in order to seek meaning of their symptoms. This meaning-finding process is carried out through the process of divination (*ukubhula) (*Ngubane, 1977). Solomon and Wane (2005) stipulate that it is a normal trend for traditional societies to continue to follow their traditional ways, which include their own traditional health facilities irrespective of modernization. This is further supported by Osagie (2002) and Crawford and Lipsedge (2001).

Puckree, Mkhize, Mgobhozi and Johnson (2002) and Berg (2003) argue that traditional healing has always been a component of health care in South Africa. A study in KwaZulu-Natal, sampling 300 traditional healers and 300 service users, showed that *izangoma* were the most popular type of healers and they had as many as 20 patients per day and were consulted for potentially life-threatening conditions (Puckree *et. al,* 2002).

However, Rudnick (2000, cited in Bojuwoye, 2005) argues that the shift to Western medicine is superficial and many patients will routinely visit traditional healers after hospitalization. This could be attributed to the fact that psychological phenomena are interpreted in different ways in different contexts and individuals with mental illness are treated differently across contexts. Thus, people will seek these different systems according to societal beliefs, irrespective of the level of modernization. This is not to say that people's help seeking behaviours are directed only by social norms and belief systems; individual characteristics such as age, gender, level of education and social status also impact on people's perceptions of illness and the treatment thereof. All these factors will ultimately direct help seeking behaviours. Acculturation, linked to increased educational levels and increased access to alternative treatment options, also influence one's help-seeking behaviours.

Lewenthal and Nerenz (1985) mention that when individuals face psychological problems, they represent the problem along five dimensions, which include identity (label), perceived cause, time line (how long it will last), consequences (physical, socially and psychologically) and curability/ controllability. These representations are drawn from social norms about the illness. There are also three types of attribution that people make to mental illness such as psychological, somatic or normalization of the illness and all are embedded in culture. Culture is therefore a strong determinant of people's perceptions of illness, its perceived causes and treatment options as compared to other personal attributes. This view is further supported by Helman (2000), who mentions that the differences in perceptions and treatment of mental illness themselves are embedded in culture and not necessarily the level of acculturation. It is culture that prescribes to people how to view the world, how to experience it emotionally and how to react to it (Solomon & Wane, 2005).

Although culture plays a fundamental role in defining what illness is and its consequent treatment, culture is never static; it changes depending on the changes in the external environment. Social, economic and political changes and personal experiences may lead to changes in people's perceptions of illness. There are differences in perception of depression between the lay public and health care professionals (William & Healey, 2001). The results from the William and Healey (2001) study indicated that the experience of depression could facilitate a reformulation of beliefs about the causes and treatment of mental health/ illness. From the research findings, one can conclude that people's perceptions are not static and locked within their cultural belief system but there are external factors such as exposure to the illness that can change perceptions. Helman (2000) further mentions that external factors include people's educational level, socio-economic status and environmental factors such as accessibility and convenience of health facilities.

The literature indicates that there are differences between indigenous and western conceptions of illness and that this has an impact on possible clinical outcomes. Furthermore, the literature also indicates that perceptions of illness have an influence on help-seeking behaviours. Finally, the literature indicates that illness is both a physical and socio-spiritual entity that requires an integrated approach attending to both aspects. There are, however, aspects of perceptions of illness that have not been extensively investigated. For example, psychological counselors', traditional healers' and their patients' perceptions of illness have not been investigated. The impact that these perceptions have on treatment and diagnosis has not been widely documented. Moreover, attitudes and views about the usage of allopathic medicines and indigenous medicine and cross referrals between indigenous and western health systems have not been widely debated and documented to influence health policy and planning and the training of health professionals. The current study seeks to shed insight into these issues.

CHAPTER III: METHODOLOGY

This section of the dissertation looks at the methodological framework used in the study. This is done by looking at the research design, which highlights the conceptual framework that informed the study by showing the link between the research questions, the purposes of the study, and the methodology used. The validity and reliability of the type of design chosen and the instruments used are also covered. The section also looks at sampling techniques and the methods of data analysis that were employed. The chapter concludes with a brief overview of ethical issues that were considered in the study.

3.1. Research Design

The research was conducted mainly as a qualitative study with the aim of investigating health providers' and health users' perceptions of illness. Denzil and Lincoln (2000) define qualitative research as multimethod in focus; it involves an interpretative, naturalistic approach to its subject matter. Denzil and Lincoln (2000) further mention that the choice of tools to be used in qualitative studies is informed by the research questions, which in turn depend on the context. They further stipulate that the research design should provide guidelines that connect the research within the conceptual framework, and the data collection method. This section will look at each of these components.

3.1.1. Research Participants

Three categories of research participants were sampled namely patients, the traditional healers and western trained psychological counselors. The overall common criteria for the participants was that all the participants needed to be Black Africans aged eighteen years and above.

3.1.1.1. Sampling Methods

Sampling the right type of participants that will best answer the research question was crucial for the study. Different types of sampling techniques were used at different stages of the research. To locate patients accessing the services of traditional healers and general

practitioners, purposeful sampling was employed. The patients were sampled from Black residential areas and public places around Pietermaritzburg. Purposeful and snowballing sampling techniques were used to sample traditional healers. Neumann (1977) mentions that purposeful sampling is appropriate when one is looking to gain an in-depth understanding of people's experiences and for content analysis.

Two key informants who are currently involved in the integration of traditional and western medicines were identified. They inturn identified people from organizations involved in integration projects and through them other participants were located. So, purposeful sampling was used to identify key stakeholders and then snowballing was used to identify other key participants. Participants should be ideal candidates to answer the research questions (Babbie & Mouton, 2001). These types of sampling techniques posed some challenges to the study by introducing potential bias to sampling: the traditional healers were located within the same social network and are likely to share a similar worldview.

Psychological counsellors were purposefully selected from two Centres providing psychological services. The criterion used was that the psychological counselors needed to be Black African.

3.1.1.2. Description of Participants

Patients

The study sampled three categories of patients. These were patients accessing the services of traditional healers and those of western trained medical practitioners.
Overall, thirty-seven patients were sampled. The patients were divided as follows: *a)* patients who had accessed the services of the traditional healers only; *b)* patients who have accessed the services of western trained medical practitioners, and c*)* patients who had accessed both the services of traditional healers and western trained medical practitioners. Patients accessing the services of traditional healers were opportunistically sampled in areas where traditional healers had their consultation rooms. Opportunistic sampling invloved strategically and purposefully targetting areas within close proximity to consultation rooms of traditional healers. Patients accessing the services of medical

practitioners were opportunistically sampled from the community. The shortcoming of this sampling methodology is that the researcher had to rely on the participants'word of mouth regarding their usage of trdaitiobnal or western healing or both. Table 1 below describes the number of patients in each category with their gender and level of education.

Table1: Distribution of patients according to age, gender, level of education and the type of services sought.

Type of service sought	***Male***			***Females***		
	Primary Education	Secondary Education	Tertiary Education	Primary Education	Secondary Education	Tertiary Education
General Practitioner (GP)	0	0	13	0	0	3
Traditional Healer Only	1	0	5	0	0	1
GP s.& Traditional Healers	1	2	0	3	7	3
Total	**2**	**2**	**18**	**3**	**7**	**7**

Traditional healers

There were initially eight traditional healers and one withdrew as a result of being nervous about being interviewed. As a result, seven traditional healers were interviewed. There were five male and two female traditional healers. There were a couple that fell in two categories, i.e. they practiced as *isangoma* and *umthandazi*. The traditional healers had gone through different initiation processes depending on the nature of their calling. Out of the seven, there were two herbalists, two spiritual healers who had also trained as *izangoma,* and three pure *izangoma*. The group of traditional healers comprised of members of the association of traditional healers that works in close collaboration with hospitals around Pietermaritzburg. All the traditional healers are currently practicing healers in their respective locations. The different categories of traditional healers sampled included *izangoma*, *izinyanga* and *abathandazi*.

Western- trained psychological counselors

Ten psychological counsellors were sampled. The term 'psychological counselor' is used to encompass both intern and registered psychologists who are currently involved in counseling. Nine of the counselors are Black South Africans from different cultural backgrounds. One of the counselor is from is from East Africa. The group of counselors was sampled from two Psychological Centres around KwaZulu-Natal and three were either in private practice or working as academics in the field of Psychology or research. The cultures represented in the sample include isiZulu, isiXhosa, Sotho and Swahili. The sample had an equal distribution according to gender.

3.1.2. Data Collection Instruments

The data were collected using three data collection instruments, namely an open-ended questionnaire, electronic interviews and personal interviews. The development of the instruments was done in phases. Each succession phase was used to clarify issues from the previous data collection and was used further to investigate issues. The first instrument used with patients was a semi-structured questionnaire based on Kleinman's (1987) explanatory model of illness (see Appendices 3 and 4). The second instrument, used with traditional healers, was a personal interview schedule (see Appendix 5). A different electronic interview schedule was used with psychological counselors (see Appendix 6). The final instrument, used with western trained counselors, was in a form of an essay type questionnaire and individual interviews. The section below describes each of the instruments in detail.

3.1.2.1. The Semi Structured Questionnaire

The research was conducted using a semi-structured questionnaire adapted from the work of Lloyd (1996, see Appendix 3). Lloyd's interview schedule is based on Kleinman's Explanatory Model of Illness. The questionnaire taps into people's perception of their illness. The areas covered in the questionnaire include the *perceived cause of the illness*, *the help-seeking behaviours*, *the severity of the symptoms* and *their explanation and lived experiences of that illness*. The questionnaire has a number of closed ended questions

relating to biographical information of the participant such as gender, age, and level of education.

The final part of the questionnaire has open-ended questions in the form of scenarios, with each scenario depicting a particular mental health problem. Patients were required to identify the type of illness depicted in the scenario, the cause of the behaviours, and the type of intervention needed to deal with the behaviour. The scenarios were created based on the examples given by Swartz (1998) in his book "Culture and mental health in Southern Africa". The questionnaire has been adapted to answer the research questions and to suit the targeted Black South African population.

The semi-structured questionnaire was well suited to address the research questions. Some of the populations in which the questionnaire has been used include White, African-Caribbean and Asians living in London. Similarly, the questionnaire has been used in African contexts such as Zimbabwe (Lloyd, Jacob, Patel, Bhurga & Mann, 1998) to study the participants' subjective experience and interpretation of their distress. Furthermore, because of its simplicity and cultural sensitivity, it can be easily interpreted and used cross culturally and across contexts. The questionnaire allows triangulation in that it allows the researcher to use both qualitative and quantitative data analysis as a means to cross check the findings, which improves validity (Tredoux & Durrheim, 2001; Babbie & Mouton, 2001).

The scenarios used in the questionnaires were adapted from Swartz (1998). To cater for the IsiZulu speaking patients, the questionnaire was translated to IsiZulu (Appendices 3 and 4). Two bilingual Psychology Masters students conducted the back translation of the questionnaire. There were some difficulties in finding the exact equivalence of some English words in IsiZulu. Similar problems were encountered as participants narrated their experiences. To compensate for that, the closest equivalent translations of the English words were used and questionnaires were given to a couple of Zulu speaking University students to read to verify whether the equivalent translations carried the same meaning as the original English words. The scenarios include a short paragraph that lists a number of symptoms and circumstances experienced by a particular individual at a given time. The patients were required to name the illness and the type of treatment that they would opt for and provide reasons for their choice (see Appendices 3 and 4).

3.1.2.2. The Interviews Schedules.

Health providers were interviewed using an open-ended interview schedule (see Appendix, 5 and 6). Ashworth, Giorgi and Koning (1986) advocate that interviews are better tools for yielding rich quality data because they are open-ended and not restrictive. They therefore do not limit or impose on the participant. Furthermore, such questions limit the influence of the researcher on the participants' responses.

Denzil and Lincoln (2000) mention that interviews are one of the qualitative methods that can be used to capture people's subjective experience. Henwood and Pidgeon (1994) further mention that qualitative methods afford an opportunity to explore issues further, enabling the researcher to cross check understanding with the participants to enhance validity. A number of studies in the field of illness have successfully used interviews to elicit people's subjective experiences. The issues tackled in the interviews include the *work as traditional healers, the diagnosis and management of illness, and their feelings about the future of South Africa's health care system*. This was done through discussions around particular cases that they had treated. Other questions emanated from the stories narrated by the traditional healers (for the interview schedule see Appendix 5).

Interviews yield a rich source of data as compared to questionnaires and other quantitative methods (Ashworth *et al*., 1986). Busch (2003) successfully used an interview schedule with open-ended questions to elicit American women's knowledge and beliefs about colorectal cancer. Lambert (2005) used the same type of data collection methods in his studies on African Art and Rituals of Divination with South African traditional healers. Again, Ngubane (1977) used qualitative research interviews to gain an indepth understanding of the lived experiences of distress among the people of KwaNyuswa in KwaZulu-Natal.

In conclusion, questionnaires and interviews were used to tap into the participants' cultural backgrounds, the nature of the presenting problem, help-seeking behaviour, interaction with physician/healer and beliefs related to mental illness. In cases where the index patient was a minor or was psychologically unfit to participate in the study, the questionnaire

aimed at getting an in-depth understanding of their families' experience of their illness and getting a sense of the factors that directed their help seeking behaviour to the health professional of their choice. This was an important aspect of the research as it reveals the social meaning and interpretation of illness. In addition, through the responses one can get a sense of how people with physical and mental illness are treated and if there is a need for familial interventions.

3.1.3. Data Collection Procedures

3.1.3.1. Data collection procedure with health service users

The data were collected using a semi-structured questionnaire that had been adapted from Lloyd (1996) (Appendices 3 and 4). The original questionnaire was modified to suit the targeted population by changing phrases and statements so that they could be relevant to the targeted population. Each of the participants was personally interviewed using the questionnaire. This was done to ensure that the research does not lose focus but at the same time does not compromise the quality of the data. Although the interviews followed the structure of the questionnaire, participants were encouraged to expand beyond the questionnaire. Surfacing issues relating to the study were probed further. The questionnaire was continuously refined throughout the data collection process and new possible areas of exploration were picked up and followed. During the analysis of the initial interviews, it became evident adhering strictly to the questions on the questionnaire compromised the quality of the data.

To increase the quality of the data from the first set of interviews, ten participants from the second set of interviews were focused on the participants' narratives; and less emphasis was placed on the questionnaire. Although the second interviews were qualitative, the data were not rich enough to draw sound conclusion and to confidently answer the research questions. This could have resulted from the fact that the issue under investigation is personal and sensitivitive. There could have also been fears because of stigma that is related to consulting traditional healers but also the familiarity between the researcher and the health care users could have impacted on the quality of the data. In-depth interviews were conducted with traditional healers to complement the data collected from the participants.

All the questionnaires were administered verbally to the participants to ensure that issues could be followed through. The questionnaire was used as a guideline to ensure standardization and to keep focus on the research questions. Each interview was approximately an hour long with small variations either way, depending on how verbal the participants were. The information given by the clients were then transcribed into the questionnaire format. This was done for all health service users.

3.1.3.2. Data Collection Procedure with Traditional Healers

For traditional healers and Western trained professionals, the procedure was slightly different. Kvale (1994 cited in Mokhosi, 2004) states that the purpose of qualitative interviews is to gather description about peoples' life-worlds, with the intention of formulating an interpretation. The initial questions emanated from the data that had been already collected from patients. Other questions emanated from the cases that were shared by the individual participants. The interviews were audio-recorded and transcribed. The interviews were all done in Zulu. Each interview took approximately forty-five minutes. On arrival at the site that was the meeting point with all the traditional healers, an introductory meeting was held. Each individual in the room was given a chance to introduce him or herself. The participants were then informed about the research and the research aims. Ethical issues, such as consent and autonomy, were explored as a group. Permission was then sought to record the sessions. The traditional healers were given an opportunity to ask questions and debate among themselves if they were happy about the audio-recording of the sessions. There was consensus in the house about the audio-recording of the session and permission was given.

The interviews were conducted at one of the traditional healer's consultation rooms. A ritual of burning of *impepho emsamu* (burning of incense) was performed and the ancestors were informed of the researcher's presence and a brief introduction of the researcher to the ancestors was made. The assistance of the ancestors with the process was sought. This was all done at the sacred room where the interviews were to be conducted. After the burning of the *impepho,* no member could enter the room with their shoes on because the ancestors were believed to be in our midst. This was done as a sign of respect to them. During that process, the assistance of the ancestors was sought in answering questions that related to

traditional healing. They referred to the process as part of *umsebenzi wabogogo*. The room had a sacred corner called *umsamu,* where *impepho* is burnt and the ancestors are invited from. The room was also filled with different types of medication, clearly labeled.

Some of the traditional healers lit the *impepho* again and called their own ancestors, *"idlozi",* as they entered the room to be interviewed. Each explained where they were and what was to happen. They then sought the assistance of the *idlozi* in answering the questions. After that ritual, the *impepho* was then extinguished. A brief introduction of the research was again given and ethical guidelines were explained to the individual. Individual consent was sought and again permission to record the session was given individually. The interviews did not follow a defined structure but questions emanated from individual experiences although there were certain questions that all the traditional healers were required to answer. At the end of all the interviews, there was a brief meeting with the remaining traditional healers to give a vote of thanks for their time and sharing of their experiences, especially when such information is sacred and personal.

3.1.3.3. Data collection procedure with psychological counsellors

A sample of psychological counselors was identified to fill in the essay type questionnaire. This was done to identify issues and themes to follow up in electronic interviews with counselors. This was further done to ensure that the study captures diverse views of psychological counselors who have had different training and work experiences. The process was a back and forward process between the data collection and analysis. For the subsequent email interviews, the participants were telephoned. Consent was sought and the objectives of the study were described to the participants. The participants and the researcher emailed back and forward questions and answers on the subject of illness and the perceived causes and the experiences of the psychological counselor working from Western models in African contexts. Pre-set questions (Appendix 6) were used as guidelines and participants were encouraged to expand on issues. (For the samples of questions asked, see Appendix 6).

3.2. Data Analysis

The research findings were interpreted using different analysis techniques, depending on the type of data and the research question. The data collected through the use of the semi-structured questionnaire was mainly analyzed qualitatively and some aspects were analyzed quantitatively using statistical procedures. The qualitative data from the interviews and the open-ended questionnaire were analyzed using content analysis. This section of the chapter looks at each of the data analysis techniques and highlights their strength in answering the research questions.

3.2.1. Quantitative analysis

The quantitative component of the research comprised of the thirty-seven open ended questionnaires from patients. The data were transcribed and coded and entered into Statistical Package for Social Science (SPSS). The codes emanated from the data and the research questions. That data were analyzed using the same statistical package. Categorical and descriptive statistical procedures, such as frequency tables and percentages, were used to analyze the data. The results were used to complement the qualitative analysis of the in-depth interviews conducted with traditional healers and psychological counsellors.

3.2.2. Qualitative analysis

For the qualitative aspect of the research, which includes the in-depth and electronic interviews with traditional healers and psychological counselors, thematic analysis was used. The interviews were transcribed in the original language used by the participants and analyzed in English. After transcribing the data summary, notes were written on each printed transcript, along the margins. The notes were not mere descriptions; they aimed at identifying the underlying meaning of the narratives, as stipulated by Denzil and Lincoln (2000). The summary and the themes were extracted in English.

The summaries were structured around five main themes that were again used as categories. The five themes were rite of passage, the treatment of illness, perceptions of the causes of physical and mental illness and the healers' views about an integrated health

system for the traditional healers. For the psychological counselors the themes included perceptions of illness and the perceived appropriate treatment options and their experiences working as western-trained counselor in an African community. During the process, there was not a clear distinction between the data collection process and the data analyses. The data were analyzed continuously throughout the data collection process to pick up themes that could be followed in the subsequent interviews. Movement to and from the data allows rigorous procedures for checking, refining and developing a good sense of the data (Charmaz, cited in Smith, Harre and Langehoven, 1996).

The qualitative data were analysed using the "Constant Comparison Method", a thematic analysis approach based on a model proposed by Dye, Schatz, Rosenberg, and Coleman (2000). The method involves taking one piece of data, for example one phrase, one theme or one interview, and constantly comparing it with others with the aim of conceptualizing possible relationships between the different data sets (Thorne, 2000). Within-case and cross-case comparisons were conducted. Responses were compared across the seven traditional healers. To begin the analysis process, the phrase as a unit of analysis was chosen (for example: *"Ngiyathandaza ngimkhulekele ngimkhulekele ukuthi kwenze ke kufike kumina kufike njengomcabango ngithathe ngithathe ngimenzele lomuntu*" [I pray and pray so that it could be revealed to me like a vision and then I prepare the treatment]). This made it easier to condense the data into manageable chunks. The interviews were done in Zulu but the interview summaries were done in English. Irrelevant information was left in the original transcript and was not summarized into the English summary sheets.

The codes mainly emanated from the literature, research questions and the data. Miles and Huberman (1994) mention that this helps the researcher not to lose focus. For example, questions around the acceptance of traditional healers by western trained professionals emanated from the interview with traditional healers and literature on proposed integrated health system in the country. The codes were either expanded or lost relevance to the study as new data were collected. Miles and Huberman (1994) stress that not all data should be coded but the researcher should be able to sift the relevant information that best answers the research question. This is what Babbie and Mouton (2001) refers to as selective coding. On-going review of the data and codes increases validity of the data because the emergent codes are better grounded in the experiences of the participants and limits imposition and

projections especially when the researcher is familiar with the subject (Boyatzis, 1998; Miles and Huberman (1994).

A conceptual definition of each of the categories was drawn up. Each of the conceptual definitions clearly stipulated the inclusion criteria in each category. Moreover, in each category there were a number of themes that made up the category. It was difficult to avoid overlap between the categories because the categories were closely related. Furthermore, the participants incorporated a number of themes that would fit into different categories into a single phrase. To deal with the problem the phrases were used in the different categories that they fell into. To distinguish between the different codes, care was taken that each code is exclusive and exhaustive and this was done using the subheading from the questionnaire.

To conclude, this section of the methodology section has looked at the data analysis processes employed to make sense of the data. The main framework used to analyze the data is the constant comparative method as described by Dye *et al.* (2000).

3.3. Validity and Reliability

This final section looks at the validity and reliability of the research design, which encompass the data collection method.

3.3.1. Reliability of the research design and research tools

Qualitative research has often been criticized of being subjective and therefore very hard to replicate. Thus, findings are sometimes considered to be lacking reliability. While quantitative research aims for a sense of neutrality and objectivity from the researcher, Denzil and Lincoln (2000) argue that one can never assume a state of neutrality as both the researcher and the participants are influenced by their culture, philosophies and ideologies. Reason and Rowan (1981) assert that validity in qualitative research lies in the emphasis on the personal encounter with the experience and encounter with persons. The encounter with the traditional healers represented a complete different world-view which I was not exposed to in my western training. The principles and the theory that shape the encounter were different. Whilst western training focused on individual consent, with the traditional

heralers the focus was on group consent. Further western training emphasise freedom of speech and being to articulate one's own thoughts and views but the focus was on the ancestors and they were asked to direct their speech and the focus was on their work. The reception and the acceptance of western training were overwhelming. There was openness to sharing and receiving from western trained professionals.

Another critique often launched against qualitative research is that it is subjective, thus running the risk of projection and collusion that may have a negative impact on both reliability and validity of the study. Craftsmanship is an important tool in qualitative research as it ensures validity and safeguards against imposition by the researcher (Denzil & Lincoln, 2000). Craftsmanship is described as the researcher's qualification, his/her competent observation and the ability to accurately record and transcribe the data. In this study, the interviews were recorded. The tapes were played and recorded word for word. The transcripts were read over a couple of times to get a feel of the data. Small summary notes were then written on the margins of the prescribed interviews. The research questions were then used as categories. Mischler (1990) refers to this process as the trustworthiness of the procedure whereby the raw data are transcribed into manageable data and results.

The interactive nature of the approach chosen captures meaning. Reason and Rowan (1981) further mention that the validity of qualitative research lies in its emphasis on the personal encounter with experience and with the participants. The personal encounter with the participants ensures that researchers can capture their emic accounts but at the same time constantly check their understanding by clarifying with the participants. In the current study, unclear concepts were clarified in latter interviews. The study aimed at investigating subjective experiences that can be easily misinterpreted, especially as an outsider. Therefore, checking and capturing the people's narratives helped strengthen the validity of the study. Qualitative validity is therefore interpersonal rather than methodological.

Reflexitivity is an important component of qualitative research (Reason & Rowan, 1981). Reflecting on the process as a western-trained counsellor, the experience was very insightful and raised questions about the reasearcher's training. The experience demystified diagnosis and the management from a traditional African perspective that is often believed to be mysterious. Moreover, the researcher was constantly aware of not using her training to judge and evaluate the tradition from a western perspective. Post the experience it

became apparent that a constant engagement of traditional and western approaches could potentially help counselors to manage illness effectively, especially in societies where illness has a socio-spiritual aspect. The researcher was impressed by the willingness of the traditional healers to accept and embrace western thought and they how they think the two systems could co-exist.

Reason and Rowan (1981) argue that qualitative research cannot be conducted alone; there is a need for colleagues who can review the data and challenge the conclusions drawn from the data. To fulfill that criterion, a colleague with both a research and Psychology background played that role of a member checker. The colleague was given the transcript and was asked to identify codes and those were compared to the initial codes generated by the researcher. In cases of discrepancies, a compromise was reached and the most suitable code was used.

To further ensure the validity of the research, especially with the traditional healers, the researcher kept close to the data. This was done through feedbacks loops and by going through the research data over a number of times (Reasons & Rowan, 1981). The data contained very sacred information about African healing and which could be easily misconstrued and therefore it was crucial that the interpretation of the data be checked with the concerned parties and relevant literature, where available. This ensured collaborative construction of reality.

3.4. Ethical Considerations

Some of the ethical considerations that were taken into account in the methodology section were the issues of consent in the participants' home language. Both group and individual consent were sought (Appendices 1 (a and b) and 2 (a and b)). In the group consent, the traditional healers discussed the details relating to the research and as a group voluntarily agreed to participate. It was emphasized to the participants that participation in the research was voluntary and declining to participate would not have any bad consequence for them (see Appendix 1a and 1b).

Before an interview was conducted, consent was sought from the participants, clarifying all the necessary information pertaining to the research. The participants were made aware of

the purpose of the study, the format in which the data will be published, the possible harm involved in the study and how that will be handled and it was stressed that there were under no obligation to participate (see Appendix 2 a and b).

The possible benefits of the study were explained to all the research participants. Such benefit included increasing the knowledge based on the lived experiences of African Black people to ensure future developments of theories applicable to the South African context. Moreover, the research also holds potential to raise informal discussions about these important issues, especially among health professionals. It was also mentioned to the participants that the data would contribute to the researcher's Masters Degree.

Confidentiality of the identifying details was stressed to all the participants. To ensure confidentiality, it was noted that the audiotapes and questionnaire were to be kept secured. It was also mentioned that only the supervisor and the researcher would have access to the audiotapes and questionnaires. It was further mentioned that because the research was about personal experiences, those participants who were to be emotionally or otherwise made uncomfortable by the research process were to be reffered to professional counsellors. Arrangements to this effect had been made with the counseling colleaugues of the reasearcher.

The chapter has looked at the methodology which encompassed the research design, sampling, data collection and data analysis. Further it highlighted the ethical issues that were addressed at the time of conducting the study and issues of reliability and validity.

CHAPTER IV: RESULTS AND DISCUSSION

The research has investigated perceptions of illness and causes thereof across a selected sample of health care users, traditional healers and western trained counselors. Moreover, the study aimed at gaining an in-depth understanding of how traditional healers and western-trained psychological counselors position themselves on western and indigenous conception of illness. Further, the study aimed at investigation health users' help seeking pathways and the factors that determine such pathways. Finally, the study aimed investigates the attitudes and views of traditional healers and western-counsellors on integrated health system and cross referrals. This chapter presents and discusses the results in relation to the literature.

4.1. Conceptions and Causes of Illness

Three main conceptions of illness emerged across traditional healers, western trained counselors and health care users: (a) illness as a symptom of ancestral displeasure (broken relationship with ancestors) as a result of disobedience, not heeding the calling or discord among family members, (b) breakdown in relationship within the community and (c) illness as an interplay of social, psychological and spiritual factors (Table 2). However, tensions between western and African conceptions of illness were noted. It also emerged that conceptions of illness cannot be divorced from perceived causes of illness.

Table 2: Summary of Perceptions across the Three Categories

Category	Ancestorial Displeasure (broken relations with clan of ancestors) due to:		Breakdown in social relationships	Interplay of Biological, Social & Psychological & spiritual factors
	Disobidience / Not heeding calling	Family Discord		
Traditional healers	√[1]	√	√	√
western trained Counsellors	√		√	√
Service users	√	√	√	√

[1] √means that the conception of illness was present for the group in question.

4.1.1. Illness as a Breakdown in Spiritual and Physical Relationships

Health, according to the study participants', is a state of equilibrium between different elements comprising the hierarchy of life that includes the spiritual world, the ecological environment and people. Any conflict or breakdown in that relationship at any level may result in illness. This is often referred to as "*ukufa kwabantu*", meaning "culture specific illness." *Ukufa kwabantu* might present with diagnosable physical symptoms. From a traditional African perspective, such symptoms are considered difficult if not impossible to treat with western medicine (Bojuwoye, 2005; Ngubane, 1977). The concept of illness being a breakdown in relationships was consistent across health care users, traditional healers and western trained counsellors, as was the view that *ukufa kwabantu* is hard to treat with western medicine (see Table 2). The category encompasses broken relationships between the individual and his or her family, the community and the spiritual realm (the ancestors).

4.1.1.1. Illness as ancestorial displeasure: not heeding the calling

The idea that illness involves a breakdown in the relationship between the individual and his/her social milieu incorporates conflict between the individual and the contemporary (current or living) family, the ancestral (spiritual) family (the living-dead), as well as occupational and social conflict in general. Of these realms comprising the possible sources of conflict, it would appear that the spiritual is the most important. A breakdown in relationship with one's spiritual family (the ancestors) could result from the failure to perform one's family responsibilities, disobeying and not appeasing the ancestors, not heeding the call to be a traditional healer and constant friction in the household but also with extended family members (*umndeni*). The following extracts talk to this issue.

Extract 1

The extract is from an interview with a male i*sangoma* and *umthandazi*. He holds both titles and uses both forms of traditional healing in a complimentary manner.

IsiZulu (Original, primary version)	**English (Translated, secondary version)**
R[2]: Kwenzeka kanjani ukuthi ube umlaphi wendabuko?	*R*: How did you receive the calling to be a traditional healer?
P[3]: Kwakuthi uma abantu bengibheka [bavele] basindeke yimina bafikelwe wulaka kungathi singaxabana, uyayizwa lento. Ngayi-searcher lento ukuthi kwenzekani ngaya kwababonayo bangitshela ukuthi "qha" mina kusho ukuthi ngingumthandazi kodwa ongahambi yedwa onobungoma phakathi, uyayizwa lento. Hhayi- ke, ekugcineni kwaze kwagcina nje sengiwuluzile umsebenzi ngalesosimo. Ngahlala ke ekhaya ngalamba nje nezingane zami azangondleka. Ngathola omunye umsebenzi ngasebenza kuwona yavuka futhi lento kakhulu abelungu bangangithanda, saxabana nabasebenzi baze bagcina sebengixoshile. Nasekhaya, ngasengihamba futhi ngiya kwabanye abantu [silence] bakwazi ukuhlola bangitshela ukuthi abakini abadingi ukuthi usebenze, udinga ukuthi usebenze abantu, uyayizwa lento.	*P*: When people looked at me they [would] just dislike me without a reason. I consulted a diviner and he/she told me that I needed to be *umthandazi* but also [one with] the spirit of *ubungoma*. I ended up losing my job because of that situation. My family and I went hungry. I found another job and worked there and again the same problems started; the employer did not like me, we had disagreements and I was fired. Even at home [we had disagreements]. I again went to the diviners [silence] and they told me that my ancestors do not want me to work, but want me to be a health care provider and serve others.

The above extract points to ancestrail displeasure which manifests itself through disagreements, misfortunes and conflicts between the narrator and the people in his context. In this case, the person's misfortunes signal that the ancestors have an unmet request or are dissatisfied about the narrator heeding the call to be a traditional healer. The breakdown or personal disintergration in this extract has a positive purpose, namely to call the person to assume a healing function in society.

4.1.1.2. Illness as ancestorial displeasure: family discord

Illness is perceived to be a result of ancestrail displeasure as a result of family discord. Continuous family disorder angers the ancestors and often illness is sent for people reconcile and mend family relation to restore the equillibrum.

[2] R means researcher
[3] P means participant

Extract 2

The extract is from one of the service users, a professional lady with tertiary education. The participant had sought the service of a traditional healer because of the illness of her son. The son had been critically ill.

IsiZulu	**English**
R: Kungani umukise ingane yakho enyangeni?	R: Why did you choose to seek help from traditional healer?
P: Umfana wami wavele wagula. Ngaqala kwadokotela kodwa odokotela nabo abazanga ukuthi unani. Siwumdeni sabona ukuthi mhlawumbe into yesiZulu *so* [ngakho-ke] ake sizame umuntu wesiZulu.	P: My son became sick unexpectedly. I first consulted a doctor but they did not know what was wrong. As a family we suspected that this might be a traditional issue so we approached a traditional healer.
R: Uthe umntwana ubeguliswa yini?	R: What did they say was the cause?
P: Uthe wukuthi bekungekho *ukuthelelana amanzi kahle phakathi kukababa wakhe kanye nobaba wami.*	P: He said it's because there was a conflict between my husband and my father.

Extract 2 highlights how ancestrail displeasure as a result of a discord among family members can cause illness. Illness is therefore a way of communicating the ancestrial displeasure about the events in the household. It is also interesting to note that the individual who manifests with the illness episode need not be directly involved in the discord. In this case, the son who is afflicted is a mere vehicle by means of which the undesirable family discord is communicated to the parties concerned.

4.1.1.3. Illness as ancestrail displeasure: disregard of ancestors

Illness is perceived to be a form of punishment or reminder of the family's dependence on the ancestors. This is in line with the African conception that illness is a form of punishment by the ancestors, which serves as a reminder to the family of their dependence on them and the need to fulfill their obligation (Holdstock, 2000; Melato, 2000; Ngubane, 1977; Sam & Moreira, 2002; Versola-Russo, 2004). It may also serve as a warning in cases where the ancestors feel neglected and not acknowledged. All the three groups that took part in this study echoed this theme.

Extract 3

This is an extract from an interview with a practising female Counselling Psychologist who also has extensive experience in the field of research and community development.

R: What do you perceive to be the causes of physical and psychological illness?

P: The cause of physical illness is the abnormalities in the physiological functioning of the body [Biological causality]. The cause of psychological illnesses is the perceived overwhelming feeling that people experience. This might be due to life circumstances or perceived problems. Also, it might involve psychotic behaviour where a client shows to be not in touch with reality. However, I have seen people who have illnesses that they attribute to other factors like Satan, or evil powers, God teaching them something , being cursed [breakdown between individual and society], [4]*ancestral communication methods*, *being punished, a calling to train as a sangoma* [breakdown between ancestors and the individuals] etc. I think what matters the most is how the patient sees his/her illness.

R: Uhmm

P: *If they think it's the medical condition or ancestral related condition it's his/her views that matter*. Obviously this determines what kind of intervention she believes will be appropriate and relevant. I am seeing a lot of students who see their illnesses as witchcraft related and I ask how they think they can be healed. If they say a sangoma, so be it. If they say a ZCC [Zion Christian Church] priest be it so. If they say I have to slaughter a goat who am I to stand in their way. If they believe it will work they will only see positive results after such intervention. You can try CBT [Cognitive Behavioural Therapy] and other methods but the client won't react to such treatment. *One of the usual cases among African clients is the cleansing ceremony after death in the family*. *There is this belief that if the cleansing ritual was never performed they attribute all illnesses to such (emphasis added).*

Extract 3 from a western-trained counsellor acknowledges the spiritual nature of illness. It highlights how illness could be used as a communication medium through which ancestors communicate their displeasure with the 'living community'. However, it should be noted that, while the respondent acknowldges this view of illness, she does not necessarily own it. What she seems to be emphasizing is the client's point of view. This issue is picked up in the discussion section later.

[4] Italics indicate author's emphasis.

Extract 4 again emphasizes how ancestrail displeasure of not being acknowldged and appeased could result in illness.

Extract 4

The extract is from a male *inyanga* (herbalist) in his late sixties. He has been practising as an *inyanga* since his youth. He was taught the art of healing by his uncles. He also interacts with other traditional healers and learns from them. The extract highlight how indigenous traditional healers also acknowldge the spiritual nature of illness.

IsiZulu	**English**
R: Baba umuntu uguliswa yini?	R: Baba what causes illness?
P: Kwesinye isikhathi kuyenzeka ukuthi umuntu aphuke umlenze ngoba kufanele kwenziwe imbeleko yengane yakhe. Ehhe umuntu angaguliswa idlozi. Kukhona okudingwa yidlozi angakwenzanga yena liyadinga ke lokho mhlambe agule, mhlambe aphuke njalo njalo. Ziningi izinto ezenzekayo uma umuntu esolwa yidlozi bese isangoma sibone ukuthi yini yona ngempela idlozi eliyisolayo ngoba awuvele ulisukele nje idlozi.	P: Sometimes someone can break a leg because they have not done the necessary rituals of introducing their child to the ancestrial clan and the family. Sometimes there is something needed by the ancestors. There are many things that can happen when the ancestors are not pleased with the person. Isangoma will see what the ancestor is unhappy about because you can't simply assume it's the ancestors.

From Extract 4 above, it is evident that illness from the perspective of traditional healers originates partly from broken relationships (disharmony) with the ancestors. Illness therefore becomes a communication tool by which the ancestors communicate their dissatisfaction with living family members' failure to meet familial and ancestral obligations. In extract 3, we learn that the Western-trained counsellor is aware of this perspective. Although both the traditional healer and the counselor agree on the spiritual and the physical aspect of illness, there are differences in the ownerships of the voice. The traditional healer owns the belief that illness is caused by ancestral displeasure. On the other hand, the counselor focuses on the view/s of the client. The counsellor's personal view is suspended. This could be the result of her training: counselors are trained not to impose their views on clients. Alternatively, this lack of ownership of the view that illness is a breakdown in spiritual relationships could indicate the conflict experienced by many Western-trained professional in harmoniously merging the traditional African view with the western view that they have been exposed to in their training (Baldwin, 1986).

4.1.2 Illness as a Breakdown in Societal Relationships

Broken social relationships between community members may also result in illness. Where there is a breakdown in communal relationships, people manipulate the environment and traditional herbs to bring about a curse to their enemies, which manifests in illness. Social conflicts include issues of jealousy, fights over partners, or even unknown reasons. The symptoms resulting from a curse might resemble the physical symptoms of illness. Other symptoms could include misfortunes, loss of employment, inability to conceive, etc. The following two extracts highlight how a breakdown in communal relationships may lead to illness.

Extract 5

The extract is from a male traditional healer with many years of practice. He was trained as both an *inyanga* and *umthandazi*. He uses both modes of healing in his practice.

Isizulu	**English**
R: Baba ngokubona kwakho ukugula kuvelaphi?	R: Father, in your perception what are the causes of illness?
P: Ukugula kunezindlela eziningi. Ukugula ehe! Kuyabangwa kwesinye isikhathi yibona abantu abadala abangasekho uyezwa. Kuyenzeka ukuthi uguliswe yibona nje ngqo. Kuyenzeka ukuthi u-guliswe abantu umphakathi ya. Ngizothi bayaku-thakatha ithi imithi efanelekile bayenze ibe ubutha. Uyayizwa lendaba ibe ubutha eke umuntu wawujomba.	P: Many things can cause illness. The elders who are deceased can sometimes cause illness. They themselves can cause illness. But members of the community can cause illness by manipulating herbs that were intended for healing; the concotions cause illness if you step over them.

Extract 6

The extract is from a thirty one year old lady with secondary school education. She had consulted both western and indigenous healers for shingles. The lady resides with her family and had recently relocated from rural areas to a township.

IsiZulu	**English**
R: Sisi, wawuyeleni ukuyobona umlaphi wendabuko?	R: Sisi, why did you consult a traditional healer?
P: Ngangiphethwe ibhande.	P: I had shingles.
R: Yini ibhande? Libangwa yini?	R: What are shingles? What causes them?
P: Ibhande amashashaza amancane anamanzi abuhlungu futhi ayanda. Uma nje ahlangana uyafa. Enziwa ngabantu. Bakubekela wona phansi wena uweqe bese uba nebhande.	P: It is a chain of small painful pimples with water. They multiply and once they form a circle around you, you die. People set up a trap that causes them and if you step over it then you get them.

Extract 7

This is an extract from an interview with a practising female Counselling Psychologist who also has extensive experience in the field of research and community development.

R: In your opinion what causes illness?

P: To answer your question, for example, in June I saw a client who presented with psychotic symptoms during exams. She was referred to me as a psychologist. If I ask her she told me that she sees zombies or utikoloshes taking away her exam question paper.

R: Oh!

P: She tries fighting it or chasing it somehow. She really believes this and mind you she came to see me and she was normal. This zombies or otokoloshe only attack her during exam writing. Upon asking her how this can be solved, she was adamant a ZCC priest can pray for her and give her Vaseline and ZCC tea to chase away such zombies. She went for such treatment and she wrote her aegrotat exams and she passed.

Extract 8

The extract is from an interview with another female Counselling Psychologist who is currently working in a Non-Government Organisation.

R: What causes illness, be it physical or psychological?

P: Sometimes you can get sick due to some cultural issues. For example the ancestors wanted you to do something and you refuse, so you may start having night sweats and all sorts of pains that the doctors cannot really find the cause for because it's from a different spiritual realm. *Sometimes so people may also be against you and bewitch you and there are cases*

of people getting sick and going crazy or having a funny rash all over their bodies. So I believe that there are different causes for illness.

The above four extracts show that illness may be a result of conflict between the individuals and members of society. Herbs intended for healing are manipulated to cause illness. Moreover, there seem to be differences in the ownership of voice between the two counsellors. The second counsellor (Extract 8) seems certain on the nature of illness and openly embraces the spiritual and the physical nature of illness whilst the previous counsellor (Extract 7) seems to be more driven by the client-centred approach and suspends her subjective opinion. This shows the differences in the practice and views in the field of health and illness. Counsellors are at different stages in trying to conceptualise and function within an integrated paradigm.

Illness is therefore complex and may be an indicator of a number of underlying issues. The traditional African conception of illness focuses on the perceived cause of ill health and not necessarily the symptoms (Ngubane, 1977; Sow 1978). Often, ancestors communicate with the family in many ways. For an example, when the ancestors are pleased with the family, this manifests in good life and good health. When ancestors are displeased or feel ignored, they cause illness or remove their protective shield over the family, thus making the family vulnerable to illness. The ancestors remove their protection to remind the family of their dependence on them (Booi, 2004; Holdstock, 2000; Melato, 2000; Mkhize, 2003; Versola-Russo, 2004). Failure to acknowledge the ancestors does not only cause illness, it can also lead to a spell of bad luck or "*amabhadi,*" which is characterized by the inability to hold long term employment and relationships, amongst other possibilities (Ngubane, 1977; Reynold, 1997). This is only one aspect of traditional African conception of illness and is based on the African ideology that ancestors are the guardians of the family. Although they have passed away, their spirits lives on and are very much involved in the running of the family.

Investigating spiritual causes is beyond the current scope of science; this highlights the need for a health care system that integrates both western-trained health professionals and traditional healers to deal with spiritual aspects, thus targeting illness from all angels (Krajewski-Jaime, 1991; Swartz; 1998 ; Versola-Russo, 2004). Traditional healers have the

spiritual power to converse with the ancestors on behalf of the family. This is based on the African belief that for the management of illness the focus needs to be on the perceived cause and that illness is a result of a breakdown in relationships (Mkhize, 2003; Ngubane, 1977; Ryder *et al*., 2002; Versola-Russo, 2004). The aim is to determine the reasons for the dissatisfaction so that health can be restored. The symptoms are not the key focus but the core is to understand the dissatisfaction or the disequilibrium and fix it, in addition to treating the body. Sometimes it is believed that the symptoms will dissipate on their own once the relational equilibrium is restored. This is in direct contrast to traditional western diagnostic criteria and treatment options, where the primary focus is on dealing with the physical (disease) aspect of the illness, with limited attention being paid to the subjective explanation and experience of the distress. This could possibly impact negatively on the therapeutic relationship and treatment outcome (Castillo, 1997; Pederson, 2002; Sam & Moreira, 2002; Vontress, 2002). This does not mean that western healing systems are not useful across contexts, only that they target a certain aspect of illness and need to be complimented with indigenous knowledge systems to provide holistic treatment. More should be done in giving a voice to the less dominant, marginalized healing systems in society.

4.1.3. Multidimensional conception of illness

Like all social constructs, concepts of illness are refined over time to compensate for the changes in the environment, which might include new negotiated social norms, exposure to alternative explanations, increased level of education, etc. The results point to the fact that, while indigenous traditional healers seem to be willing to and already operating within an inclusive paradigm, it is only now that western-trained psychologists/counsellors are beginning to integrate western and traditional African conceptions of illness.

Extract 9

The extract is from an interview with a female educational psychologist in her early thirties.

R: As an African who has had Western training, how do you understand the concept of illness?

P: My understanding of illness is not only influenced by my training but also my experience in my work with my clients. Illness is anything that causes an individual discomfort, whether

psychological or hysterical [physical]. The sources could be different biological or environment, which for me also includes cultural aspects.

R: Such as?

P: An individual may be seen [present for counseling] as a result of a traumatic, experience in the West but I would prefer to view it from the individuals understanding. If he agrees it is a result of a traumatic event then fine I would treat it as such, but if he thinks his ancestors are not happy then I would refer him to a place where he can be helped to work through his ancestral issue.

Extract 10

The extract is from an interview with a male mental health care worker who is practicing as a student counselor.

R: As an African who has had Western training how do you understand the concept of illness?

P: It is a state of health whereby the system (body) has been inconvenienced by outside or genetic forces. The understanding from the Western view is that a reason [to determine the cause you] will need laboratory-analyzed medicine to suit the person‘s system and bring about stability in terms of functioning. *The African way seeks the roots of illness from the relationship a person has with his/her ancestors*. [For an] example: in Western culture they talk of a psychosis whereas in African culture they might slaughter a goat and seek direction from ancestors [to determine] whether [the person] has a calling to be a traditional healer.

While the counsellor cited in Extract 10 above seems to be aware of alternative conceptions of illness, including the African perspective, he does not choose one over the other nor does he accept and own the intergrated approach. The counsellor seems conflicted between the two world-views. The basis of this understanding still lies in the traditional African conception that illness is a breakdown of social relationships, be they spiritual or physical relationships. This confirms early findings in the field. A study conducted by Patel (2001) on an elderly Zimbambwean sample showed that the onset of depression among this sample was associated with marital and other relationship crises, deaths and events related to fertility and pregnancy.

The theme is prevalent across the groups irrespective of level of education. Irrespective of the socio-economic and political changes in the country, cultural ideologies remain resistant to change. The results support previous research findings (Swartz, 2001; Rudnick, 2000, cited in Bojuwoye, 2005; Castillo, 2004; Ngubane, 1977). This also confirms the finding of previous study on the Babile tribe in Somalia. Slikkerveer (1992) found that, irrespective of the free western health care, ethnomedical traditions were much stronger determinants of the pattern of use of the modern and transitional system than any demographical, socio-economic factors and proximity. Such ideologies still form the social fabric of society. It is these ideologies that are used as meaning making mechanisms. The breakdown in the relationships leads not only to illness but also other social ills such as immorality, crime, and poverty.

The co-existence of Wetern and indigenous conceptions of illness has major implications for the use of Western diagnostic criteria in an African context, without taking into account the culturally and socially constructed nature of illness. Western criteria do not capture the spiritual or relationship element of illness. The 'broken relationship' element can only be diagnosed through a spiritual process that involves the ancestors and traditional healers (diviners). Pearce and Wilson (2007), based on their study on Parkinson disease in Africa, mention that the use of traditional healers in African countries is not only based on ethno-medical theories but also the health resources in these countries. Aikins (2005), based on his research findings on healer shopping in Africa, makes the same recommendation that lack of economic resources will lead to shift from biomedical care to traditional healing. The research findings indicate that irrespective of the health resource, ethno-medical theories remain dominant.

While Western criteria are more suitable for diagnosing and treating the disease aspect of illness, they generally fail to capture the subjective meaning and experience of distress. This therefore highlights the need for a holistic perspective to illness that will cater for both the disease and subjective aspect of illness. Failure to capture patients' subjective experiences leads to the treatment of the disease aspect only; the patients' illness narratives, their subjective accounts of their distress (the illness experience) which are generally considered to be the 'root cause of the illness' from an indigenous perspective, are left unattended. Such an approach has been shown to have a negative impact on treatment

adherence **(**Castillo, 1997). Further, research shows that effective treatment is holistic; it incorporates biological, social, and political and cultural aspects of human life. For an example, a study by Jain and Agrawal (2005) on the Bhilian sample illustrates how the health system can integrate traditional and western treatment options at community and state levels. Western and traditional systems co-exist harmoniously. This is an advanced stage of development and South Africa still needs to address issues of exposure and acceptance of alternative explanatory models. This highlights the need for integration of Western and indigenous healing methods. More important is raising awareness among health providers about the cultural meanings of distress.

4.1.4. Illness as a Complex Interplay of Socio-cultural, Psychological and Economic Factors.

The findings indicate that illness is a complex interplay of social, cultural, psychological and economic factors. A large component of illness involves subjective experiences and the family realities of the distressed person (Rudnick, 2000 cited in Bojuwoye, 2005; Castillo, 1997; Vontress, 2004). Illness therefore can be a conglomeration of biological, psychological, social and cultural factors. The concept of illness is only attributed to states that the community classifies as such and symptoms outside the societal consensus are not perceived as such.

Extract 11

The extract is from an interview with a female participant who has been practicing as an i*sangoma* since her youth.

IsiZulu	**English**
R: Ma, yini izizwe?	R: Ma, what is izizwe?
P: Ufufunyane	P: Ufufunyane
R: Luyini?	R: What is it?
P: Luyizizwe. Lwenziwa womunye umuntu, luyathakwa.	P: Yizizwe. Others cause it through sorcery.
R: Oh!! Bese uyalwenza bese [umuntu] uyasangana.	R: One then becomes insane?
P: Yah bese [umuntu] ucosha namaphepha, athwale izidwedwe eziningi uma umbona lomuntu othwala izidwedwe wahlanyiswa ke.	P: Yes! You start picking up papers and cloth yourself with many dirty clothes.
R: So mama ukwazi ukubona ngani ukuthi lo uhlanyiswe yini?	R: Ma can you distinguish the different causes of insanity?
P: Abantu abadala bayakwazi ukuhlukanisa.	P: Ancestors can distinguish between the different causes of insanity
	R: Do the ancestors tell you individual treatments and if you need to refer?

Bayakutshela bethi lo singamulapha noma qha lona ufuna udokotela.
R: Bayakutshela ukuthi ubani ufuna ini?
P: Ehe lo ufuna odokotela noma ama-Psychologists aze omunye asangane kanti ufuna nje ukuthethwa ngomlomo noma lento leyo ke ungayithatha kanjani ukuthi abantu abadala kufanele agcine amasiko akubo uyayazi exactly into emhlanyisayo.
R: Ehe
P: Omunye udla insangu iye emqondweni ahlanye usedakwe zidakamizwa.

P: Yes, they will say that this one needs doctors or Psychologists because they just need therapy. Sometimes it is because they have not performed the necessary rituals in their culture and that causes mental illness.

R: Yeah
P: Sometimes its substance [dagga] abuse that will cause mental illness.

This biological nature of illness coexists with the spiritual aspect of illness. Illness with a spiritual origin can manifest as a physical illness, thus making it complex to separate the two. This then informs treatment of such illness. From the traditional healers' perspective, the emphasis is on spiritual aspects that can manifest biologically, psychologically, socially or economically. Similarly, western trained professionals perceive illness to be an interplay of social, psychological, and contextual factors (see Extract 10).

Extract 12

The extract is from an interview with a Counselling Pschologist who is currently invovled in community research but also has experience in student counseling.

R: As a Black counselor with Western training and working in African societies, what do you perceive to be the cause of illness?

P: I hold close to my heart the idea that individuals are part of a broader system and any disturbance to the system or part of the system, for me, thus makes them vulnerable to both physical and mental illness.

R: Uhmm…

P: I understand the system as consisting of social lives (including friends, families and culture), economical as well as political standing and the physiological components. Thus a negative impact in any part of the system leads to illness and these may also have an overlapping impact on one another. For instance, with the participants in my breast cancer study, after receiving the diagnosis of breast cancer (physical), some have developed symptoms of depression (mental). And when you come to think of it, we have seen unemployed housewives who have been left by their husbands (family disintegration), developing major psychological symptoms (such as depression), giving rise to eating disorders and eventually physical complications (eg. Obesity and heart

problems). *And you can see ukuthi [that] with this example; socioeconomic as well as psychological factors all come into play. So the way I see it, situations may be unique, with some just having one cause but with some having interlinked causes.*

Western-trained professionals, however, do not place as much emphasis on the spiritual aspect of illness as do traditional healers. The possible cultural causes of illness are acknowledged and perceived to be a reality but it is left to the client to seek alternative treatment. This is contrary to the traditional healers who not only acknowledge the role of western trained professionals but also refer their clients to them.

Extract 12 further indicates the complexity of drawing up a comprehensive reality that can capture people's experiences of illness. The concept of illness is not just a scientific entity that can be studied in isolation. It involves social, psychological, cultural and economic factors but more especially subjective interpretations and meanings given to the distress (Matsumoto, 2001; Ngubane, 1997; Patel, 2001). The results therefore confirm earlier findings in the field. Studies in a Chinese sample indicate that, although the different categories of mental illness exist in these communities, the presentation, prognosis and meanings are different from western societies (Ritts, 2005). Drawing treatment guidelines in a vacuum excludes people's realities and misses on the essence of illness but captured the disease component of illness. Extract 11 from the traditional healer also emphasizes the spiritual nature of illness, while western trained counsellors do not mention the spiritual aspect as part of the interplay between social, psychological and economic aspects.

Although some western-trained counsellors successfully merge indigenous and western conceptions of illness, as in Extract 12, there are still conflicts experienced by western-trained professionals in merging indigenous and western conceptions of illness. They see them as opposing world-views.

4.2. The Relationship between Western and Indegenous Views of Illness: The Positioning of Western-trained Counsellors and Indegenous Traditional Healers.

The results indicate that although western-trained professionals are forging a new reality that is redefining illness, incorporating western and indigenous beliefs, there are however perceived conflicts between western and indigenous conceptions.

Extract 13

The extract is from an interview with a male intern psychologist in an insititution of Higher Learning.

R: Being an African, do you find yourself conflicted between your African views and what you have been exposed to in your training?

P: Yes, I do find myself feeling conflicted between my African views and those of the west. Western views brought new understanding and perceptions of situations and circumstances including conditions surrounding human nature. For an example, if a person presents with a chest pain, the medical model will do tests and scans to trace any impairment at the biological level whereas psychologically they would look at the emotional, deep seated issues but the African view [would say that] you are bewitched or *udlisiwe* [poisoned].

Extract 14

The extract is from an interview with a female psychologist originally from a neighbouring country. She is employed as a coordinator of a community based organisation.

R: Being an African, do you find yourself conflicted between your African views and that you have been exposed to in your training?

P: *The difficulty is in understanding the things that they explain that seem almost unreal that happen or have to be done before they get better. Because the western training does not often teach you to accept what is unreal or dubious because it means someone is psychotic for example if someone says the ancestors spoke to me. The western teaching says but they are dead [ancestors]*. The challenge in the work is to accept other people's reality and not assume they are mentally ill and start to diagnose them. The other challenge is their appraisals. They believe they are sick maybe because someone is jealous of their progress. In western terms it would be seen as externalizing blame and

problematic. The client often knows himself or herself best and they will guide you to a mode of healing that works best

Extract 15

The extract is from a female counselling psychologist working in an institution of higher learning as a community researcher.

R: Being an African do you find yourself conflicted between your African views and what you have been exposed to in your training?

P: I think at a personal level, no, as I am able to integrate and make meaning for myself. But it has happened at some point that I was working with somebody that I could clearly see *ukuthi* [that] they needed psychiatric evaluation but the person insisted on a traditional explanation of their condition, which was completely opposite to what I was seeing. I have complete respect for all forms of explanatory models and I completely believe in the negotiation and integration of western and indigenous forms for the achievement of well-being but when individuals that we come across aren't willing to adopt an open mind, then I really find myself in a conflictual situation. *So in essence, it is a matter of being torn between wanting to intervene in every way and achieve the best and at the same time being faced with a resistance that almost makes you resentful towards your own African indigenous explanations since at that point they seem to kind of stand in the way of your intervention.*

The above extract (Extract 15) indicates that some western-trained professionals have managed to forge their new reality that can accommodate the two, often opposing African and western conceptions of illness. At the same time there is a sense that these western-trained professionals live in two, sometimes opposing worlds, and the type of work they do often requires them at times to choose between the two. For an example, in cases like *ukuthwasa,* where the symptoms are classified differently in the two worldviews, counsellors are faced with a difficult choice to make, which is complicated by the fact that *ukuthwasa* presents with symptoms that resemble the early onset of schizophrenia. In Extract 14, the participant's statement that "*The difficulty is in understanding the things that they explain that seem almost unreal that happen or have to be done before they get better. Because the western training does not often teach you to accept what is unreal or dubious because it means someone is psychotic for example if someone says the ancestors*

spoke to me" deserves special mention as a good example of the tensions felt by some African psychologists. The statement indicates that, while the participant appears to be distancing herself from this view on the one level, on the other level there is a willingness to work with that reality. The willingness to work with that reality could be stemming from the cultural knowledge that such explanatory models exist and are true within the African communities. This is based on the African conception that illness is not just a physical entity but reflects social and spiritual elements (Castillo, 1997; Matsumoto, 2001; Ngubane, 1977; Versola-Russo, 2004). Krajewski-Jaime (1991, cited in Versola-Russo, 2004) mentions that, while the lay public has successfully negotiated traditional (indigenous) and western conceptions of illness throughout the years, the response from the professional sector has been quite slow, and South Africa is no different.

Extract 14 above highlights the complexity of receiving western training and practicing in contexts with different worldviews. It would even be more complex for professionals who are not exposed to the illness conceptions of the community in which they practice (Sam & Moreira, 2002; Matsumoto, 2001). It is possible that the differences between health care workers and service users in understanding the aetiology and meaning of illness have a negative impact on diagnosis and treatment (Lindenbaun, 1997). This is particularly so because, while diagnostic criteria are assumed to be culture/value free, in essence they reflect the reality and culture of particular contexts (Barlow & Durand, 2001; Castillo, 1997; Kaplan, 1994). For example, while western cultures emphasize the psychological (cognitive) aspects of depression, it has been shown that in Asian and African cultures bodily (physical) symptoms tend to dominate the clinical picture, a situation generally attributed to the absence of the body-mind dualism in these cultures (Kleinman & Good, 1987; Markus & Kitayama, 1991; Matsumoto, 2001; Ryder *et al*., (2002; Sam & Moreira, 2002; Tanaka-Matsumi & Chang, 2002). It is therefore problematic when diagnostic criteria are applied cross-culturally, without due consideration of the illness conceptions and explanatory models of the culture concerned, as this creates room for overdiagnosis or underdiagnosis of illness. Health professionals, especially African psychologists trained in the western framework, are faced with an ethical dilemma: on the one hand they want to respect the culture and illness explananatory models of their clients but at the same time they have to contend with the possibility of overlooking illnesses that are treatable (or, at least, can be contained), from a psychological or psychiatric perspective.

As we learn from Extract 15, the concept of illness is not limited to the disease aspect; it incorporates patients' subjective accounts of their distress, which are based on their worldviews or meaning making-systems. Often, there is a clash between western classification systems and the patient's subjective experience, which may negatively impact on the clinical outcome (Castillo, 1997; Helman, 2000; Patel, 2000; Pedersen, 2002; Vontress, 2002). Illness is a social construct and the subjective experience is embedded in one's cultural identity and ideologies which vary from context to context (Chakavati cited in Kelly & Lewis, 1987; Lavita, 2000; Ryder, Yang & Heini, 2002; Sam & Moreira, 2002). Culture shapes the idiom of distress; people from different contexts will have different constructions, understandings and experiences of distress (Castillo, 1997; Kleinman, 2004; Tanaka-Matsumi & Chang, 2002)

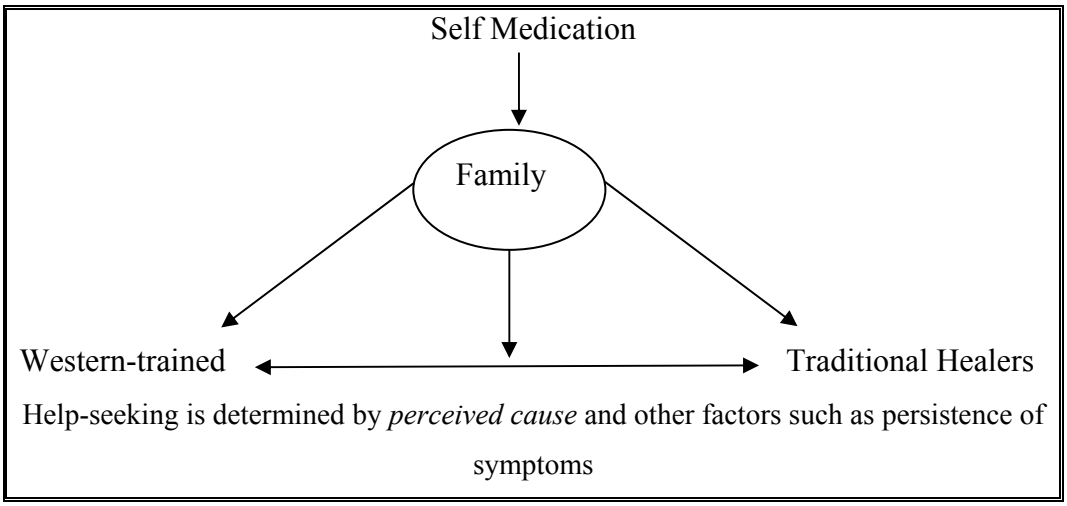
As far as practice is concerned, the dilemma arising from competing explanatory models is felt most by African western-trained professionals because, while they have informal knowledge of alternative explanations of illness, their training does not usually prepare them to reconcile indigenous and western approaches to healing. Howeer, despite their western-type training, all African participants in this study either held both the western and indigenous conceptions of illness or were at least aware of and acknowledged the latter's existence among clients/patients. Further complicating the picture, a large number of health professionals in South Affrica are from different cultural backgrounds to their clients (Pillay & Kramers, 2003). The focus needs to be on conscientizing health professionals of the differences that exist so that they can create space to hold their clients' conceptions of illness (Castillo, 1997; Versola-Russo, 2004; Sam & Moreira, 2002). Psychology students should be exposed to competing/alternative health care systems in their training, in line with the holistic approach to health envisaged in the Alma Decaration as well as the country's Primary Health model of care (Patel, 1999; Thistlethwaite & Jordan, 2002).

4.3. Help-Seeking Pathways

Help-seeking pathways refer to the rationale that directs people's responses to illness. Help seeking is a process that starts from the time of infection till the point of contact with health providers. The research findings indicate that help-seeking pathways are social in nature and are based on perceived causality. For traditional healers, western trained counsellors and health care users; help-seeking pathways were linked to the *perceived cause(s)* of

illness. The research findings also indicate that help-seeking pathways include consultation with family members, then the diviner, *inyanga* or doctor. These can also be consulted simultaneously depending on the perceived cause. Figure 1 indicates overall help-seeking pathways as identified by the three groups.

Figure 1: Help-seeking pathways



4.3.1. The role of the family in help-seeking behaviour of health care users

The responses from the health care users showed that consultation starts within the family. It is the family, based on experience and culture, which decides the type of help that would be appropriate for the symptoms. When uncertain about the perceived cause, both western and traditional healers are consulted on a trial and error basis. In other cases of uncertainty, the nature of the illness is used as a determinant of the type of treatment needed. For example, physical illnesses are referred to doctors or *izinyanga* and spiritual or psychological illnesses are referred to diviners (*izangoma*). The consultation of the family is crucial because illness is not only about the individual; it is a family issue. Table 3 provides a summary of the help-seeking behaviours of the health service users in the current episodes.

The results show the social nature of help-seeking pathways. Help-seeking behaviours are negotiated between the individual and family members, based on the perceived cause of illness. The findings are in line with the African belief that family play an important role in the process of decision-making in the life of the individual (Lukutati, 1977; Nsamenang, 2000).

Table 3: Help seeking behaviours of health care users

Help seeking pathways	
Family then accessing services of General Practitioner;	21.6%
Family and then accessing services of an Traditional Healer	24.3 %
Family then Western practitioner and then consulted Traditional Healer	32.4 %
Traditional healer and then consulted Western Practitioner	5.4 %
Traditional Healer	2.7 %
Western Practitioner	10.8 %
Self medication	2.7 %

In addition to *perceived cause*, Table 4 shows that health care users' help-seeking pathways are also influenced by accessibility of health facilities, previous experience, religious beliefs, persistence of symptoms after consulting the first time, and advice by others rather than family members.

Table 4: ***Users***' ***determinant of help-seeking behaviours***

Determinant of help-seeking behaviours	
Accessibility and convenience	10.8%
Belief system	10.8 %
Perceived cause	40.5%
Previous experiences with the same professional & credentials	13.5%
Failure of other professionals	21.6%
Advised by others	2.7%

Help-seeking pathways are social in nature: they involve consultation first within the family and then beyond the family (Rogler, Dharma & Cortes, 1993; MacKain, 2003; Vontress, 2002; Versola-Russo, 2004). Based on the nature of the *perceived cause* and previous experience, the decision is made on the appropriate source of help. There is no predetermined help-seeking pathway; each case is viewed on its merit (MacKain, 2003; Solomon & Wane, 2005l; Ngubane, 1977). If the cause is perceived to be *umkhuhlane,* often the services of western health providers are sought. When illness is perceived to be "*ukufa kwabantu*", then traditional healers are consulted. Traditional healers are also

consulted for *imikhuhlane*. In cases of uncertainty, western and traditional healers can be consulted simultaneously or at different stages during the course of the illness (Ngubane, 1977; Booi, 2004; Puckree *et al*., 2002; Swartz, 2001). This lends credence to the view that help seeking behaviours in African societies are more complex than in western societies (Rudnick, cited in Bojuwoye, 2005; Helman, 2000; Levental & Nerez, 1985).

It was noted above that accessibility and convenience was one of the major determinants of help-seeking behaviour for participants in this study. The advent of democracy has increased access to health care facilities to communities that previously did not have access to these institutions (Annual reports of the Department of Health, 2003, 2004, 2005). Access to these facilities also introduces new help-seeking behaviours as previously held realities are defined. While it is plausible that more people are now accessing western-type health care facilities than before, it is highly unlikely that this has replaced the use of traditional health institutions. Indeed, findings by Crawford and Lipsedge (2004) indicate that Zulu people consult both western and traditional healers for mental health problems and general distress. Western healers are consulted for cure while traditional healers are consulted to identify the cause of the distress.

The help-seeking pathways highlighted above are congruent with the holistic, indigenous conception of illness that incorporates physical, social and spiritual components (Booi, 2004; Holdstock, 2000; Mkhize, 2003; Ngubane, 1977; Versola-Russo, 2004). Health care users will therefore use the services of traditional healers to gain knowledge about the cause of the distress, based on the indigenous conception that illness results from a breakdown of social relationships. This confirms earlier findings in the field that people will seek traditional and western facilities to deal with distinct aspects of illness. The decision is based on the merits of each case (MacKain, 2003; Swartz, 2001). There are no predetermined steps that guide help-seeking behaviours. Rather, what matters is how the individual, in consultation with the family, makes sense of the distress.

To summarise this section on help-seeking pathways, the findings highlight the importance of a comprehensive health care system that provides for both western and indigenous health care systems. An analysis of help-seeking pathways indicates that patients are already accessing both health-care systems, without referrals. Rudnick (2000 cited in Bojuwoye, 2005) argues that the shift to Western medicine is superficial; many patients routinely visit

traditional healers after hospitalisation. This situation holds in many African countries, including Nigeria (Osagie, 2002) and Botswana (Steen & Mandoza, 1999), to mention only a few. Often, this is done in secrecy: western-trained professionals are not informed about the use of traditional health institutions. This may pose negative consequences because the effects of the simultaneous intake of western and indigenous medicines are unknown. Communication between the two health care systems that continue to exist in parallel to each other will go a long way in addressing these problems.

4.4. Attitudes Towards Cross Referrals

There are attempts by the national Department of Health to integrate western and traditional medicine with the view that this will increase access to services and provide a holistic approach to treatment (Department of Health Government Gazette 31271, 2008).The draft policy on African traditional medicine advocates for cross referrals, increased access to health care, redress of past inequalities and inclusion of traditional healing system into the mainstream health care system. This was the theme used in this research to capture the health workers' feelings and views about cross referral between traditional and western trained professionals. Western-trained professionals had mixed feelings bout referring their clients to traditional healers. On the other hand, traditional healers are fully open to referring their clients to western-trained professionals and are already doing so. The views of the two stakeholders as far as cross-referrals are concerned, are captured in summary form in Table 5.

4.5.1. Traditional healers' attitudes about cross referrals

Overall, both western-trained health care professionals and indigenous healers see the value of cross-referral because of the complexity of illness. Traditional healers have been referring their patients to western facilities. There is a general consensus among traditional healers about the importance of western medicine, especially in treating *imikhuhlane* (biological illnesses) and illnesses such as HIV/AIDS and diabetes. There is also a perceived potential of sharing information and learning from each other.

Table5: Summary of views and feelings about cross referrals.

	ATTITUDES	ADVANTAGE	CONCERNS
Traditional Healers	•Positive and accepting of western-trained care providers •Feels complement their work. • Willingness to share expertise. •Gladly cross-refer. •Skeptical about referral	•Western trained healers play a role in diagnosis in cases of HIV/AIDS •Role in resuscitation of patients and the treatment of biological conditions. •Compliment their treatment	•Their own level of education in terms of documentation •Non-acceptance by western-trained health care providers •Lack of trust by western-trained health care providers
Western trained Counselors	•Acknowledge the role of cross referral •Lack of trust and uncertainty about referral to traditional healers •Question the education level and the expertise of some traditional healers	•Acknowledge that traditional healers can treat the spiritual aspect of illness	•Level of education of traditional healers •Traditional healers are not regulated to ensure quality service. •Western and African are perceived to be conflicting views of illness

4.4.2. Advantages of Cross-referrals: Traditional Healers

Traditional healers value cross-referrals and have always been referring their clients to western-trained professionals for treatment.

Extract 16

The following extract from a female *isangoma* or diviner in her late fifties illustrates how traditional healers embrace western medicine. She treats both mental and physical illnesses in her community.

IsiZulu

R: Mama kuyenzeka uthumela abantu kodokotela besilungu?
P: Ngiyasho. Kuyenzeka mhlawumbe ngiyabona ukuthi unesifo mhlawumbe ngiyabona ukuthi lesisifuba sakhe kodwa ayi! Besengithi akaye kodokotela eyothola

English

R: Do you sometimes refer your clients to Western doctors?
P: Yes, it happens when I am uncertain about a particular illness that I will refer the client to the doctor for medication and I will also give medication. When an individual needs

amaphilisi noma ngimenzela nami kodwa kufanele athole amaphilisi. [Ngiyabazisa ukuthi] amandla awasekho kakhulu; [maba]hambe [ba]ye kudokotela [ukuthola]ama Drip azokubuyisa amandla ngoba imithi kuyenzeka kwenye indawo ibe-strong manje sithi qala kodokotela bakunike amandla ngama Drip kanye nemijovo ukwazi-ke, uzothi uma ubuya ke ngoba eminye [imithi] ibuye ithathe ngolaka.	resuscitation then I refer to a doctor for [a] drip. This also strengthens the immune system of the client so that we can begin treatment with our herbs that are often stronger in the sense that the person needs to be stronger/well to take the medications.

The extract highlights how western medicine is perceived by traditional healers to be complementary to traditional medication. Each is perceived to deal with a different aspect of the illness. People are encouraged to use both simultaneously.

Extract 17

The extract is from an *inyanga* who has formal training in African medicine. He functions as a traditional pharmacist. In his service he works closely with *izangoma* and western-trained professionals to diagnosis illnesses.

IsiZulu	**English**
R: Baba uke uthi abantu abaye kodokotela?	R: Baba do you refer your patients to western doctors?
P: Yah, njengokuthi ushukela awusifuni isilonda so kufuna umelaphe ngezinye izindlela kungcono umthobe. Manje kubalulekile ukuthi umuntu makahambe aye emtholampilo. Ezinye futhi izifo lezi ezihlobanayo nomeqo yilesisifo esikhona ngoba naso siqeda amandla naso senza izilonda okusho ukuthi lapho uma ubona lomuntu onjalo kubalulekile ukumcela ukuthi akaye ko-tester kodwa nivumelane naye niqondisane ukuthi aka-checke naso lesisifo khona uzogadla wazi ngoba seziningi [izifo] ezikhona. Ukuqala kwami ngama '60s njengoba ngishilo ukuthi ngaqala ngama '60s sezandile izifo sekukhona ushukela sekufanele ke nabo dokotela [sisebenzisane nabo].	P: Yes, like in the case of sugar diabetes. You can't cut a patient with diabetes [i.e. make an incision to administer traditional medicine] because the condition will worsen. It is therefore important that you send the person to the clinic. The symptoms for diabetes are similar to those of *umeqo*. People with *umeqo* will also lose energy, swell and people will develop sores. Because of that it's crucial to refer [patients to the doctor] but one must obtain the client's consent though. This is done to ensure that the client receives the appropriate treatment. When I first became an *inyanga* in the '60s illnesses have become more complex and that calls for an integrated approach to treatment.

The extract above emphasizes the importance of cross referral for confirmation of diagnosis and the correct treatment of illness. Moreover, cross-referral is perceived to be more important now as illnesses have become complex.

4.4.3. Attitudes and concerns of both western trained and Indigenous healers

While traditional healers openly refer their clients to Western-trained professionals, the latter do not appear to have fully accepted the notion of cross–referrals between the two systems. Western trained professionals in this study were sceptical about the services rendered by traditional healers and preferred that clients decide on their own.

Extract 18

The extract is from an interview with a male mental health worker practising as a student counsellor in one South African institution of Higher Learning.

R: What are your feelings about the proposed integrated health system?

P: On the surface it is an excellent idea but there are great challenges underneath as there needs to be some form of regulation and procedural aspects laid out for practitioners from both sides but much more so practitioners from the indigenous systems because it will only be of late that they will be formally recognized and they have for a long time not functioned under any regulations. There might also be tensions between health practitioners from both side when it comes to such aspects as referrals, treatment adherence and all those things. Overall, it is a good idea that has been long overdue but South Africa has a tendency of devising glossy programmes and regulations without paying attention to the details and the things that really matter as they impact on implementation.

Extract 19

The extract is from an interview from a male *inyanga* in his late sixties. The calling has been passed down through generations in his family. He has been practising for many years.

IsiZulu	**English**
R: Baba wena ubona ukuthi odokotela besintu bangasebenzisana nodokotela besilungu?	R: Baba in your opinion can western trained professionals work with traditional healers?
P: Bangasebezisana nodokotela besilungu. He! Ukuthi isikhathi esiningi laba abamhlophe abamthembi umuntu kanti bayehlulwa (long silence) ba-strong kakhulu odokotela besintu kunabesilungu.	P: They can. [Exclamation!] It's just that most of the time Western healers do not trust indigenous healers irrespective of the better service they provide. Traditional healers are better than western doctors.

Extract 18 shows that there are however concerns among western-trained professionals about the regulation of the field of traditional healing. Furthermore, there were concerns about the quality of the service that the sector is rendering to their clientele. Moreover, another concern was with regard to the legislation advocating for the integration. There is a feeling that the legislation is good on paper but the implementation is poor. Moreover, the challenges mentioned include the definition of normality across the two systems, which may sometimes be conflicting (for example, the issue of *ukuthwasa* (see Extract 14).

Meanwhile, traditional healers raised concerns about their acceptance by western trained professionals (see Extract 19). Some of the concerns include issues of trust by the western trained professionals. Moreover, there were concerns about the implementation being fraught with irregularities. Finally there were concerns that western trained professionals do not understand the African conception of illness. This creates barrier in trying to force a new South African reality that can be representative of the people on the ground.

4.5. Summary and Conclusion

The research has shown that traditional healers, western-trained psychological counselors and their patient all view illness as complex and multi-dimesional. Illness is perceived to encompass both subjective interpretations and physical objective symptoms. This explains the different roles which are perceived to be played by traditional indigenous healers as compared to western trained health professionals. Western trained professionals are perceived to mainly target the disease aspect of distress whilst traditional healers specialize in the meaning making process about the illness.

In terms of an intergrated health system that gives space to both western and tradityional medicine, there are conflicting views between western trained professionals and traditional healers. Traditional healers seem to embrace the idea of an intergrated health system and readily refer their clients to western trained professionals. African healing makes space for biological causes that can be treated using both western and traditional medicine. It is understood that illness is complex and multi-dimensional and therefore needs to be targeted at the different levels (Ngubane, 1977; Sow, 1987). The two sectors therefore complement each other to ensure holistic treatment in order to address both the disease and illness aspects of distress. Traditional healers were also of the view that they were not fully accepted by western trained professionals.

Western trained professionals on the other hand acknowledge the importance of a wholistic approach to management of illness. There is however a skepticism about the services offered by traditional healers and referring their patients to traditional healers.

Meanwhile, health care users/patients make use of both western and traditional (indigenous) health institutions without being referred by their health providers; the two health care systems are seen to be complementry. Family plays an important role as far as help-seeking pathways are concerned.

It has been argued that there needs to be greater collaboration between the two health sectors, in line with the principles of Primary Health Care that has been adopted by the country.

CHAPTER V: CONCLUSIONS AND IMPLICATION

The research had aimed to investigate perceptions of illness and causes thereof across a selected sample of health care users, traditional healers and western trained counselors. Moreover, the study aimed at gaining an in-depth understanding of how traditional healers and western-trained psychological counselors position themselves on western and indigenous conception of illness. Further, the study aimed at investigation health users' help seeking pathways and the factors that determine such pathways. Finally, the study aimed investigates the attitudes and views of traditional healers and western-counsellors on integrated health system and cross referrals. This chapter presents the conclusion and the implication thereof for theory, policy and practice and future research.

To conclude, the findings have showed that the conception of illness is multi-dimensional and complex for both health providers and users, reflecting the African worldview of illness (Ngubane, 1997; Holdstock, 2001). Illness is understood and interpreted in context, taking into account the events preceding the illness and perceived causes. Illness, according to the people's lived experiences, is perceived to be not just a physical phenomenon but also a spiritual phenomenon. Illness is therefore perceived to be a result of a breakdown in social relationships or in the spiritual realm or a result of biological and hereditary factors. This explains the multifaceted approach adopted by the people in dealing with illness. Western and traditional healers play complementary roles in the treatment of illness. The roles of indigenous and western trained health professionals are not perceived by health care users and indegenous helaers to be conflictual, but are understood to be addressing different aspect of the illness. Western trained professionals play a more important role in the biological aspect of illness whilst traditional healers place emphasis on the spiritual aspect of illness. This is not to say that traditional healers are not also consulted for biological aspects of illness and vice-versa. Traditional healers are also consulted for straight physiological cases. Western trained professionals may be consulted for spiritual illnesses.

These findings support previous findings in the area of perception of illness that people from African background use both Western and traditional health simultaneously because they are perceived to be complementary and as targeting different aspects of illness (Swartz, 1998; Holdstock, 2000). This is the similar view held by traditional healers as they

readily cross-refer their patients to Western trained health professionals. Western trained professionals, on the other hand, acknowledge the physical, social, psychological and spiritual nature of illness but are somewhat reluctant about cross referral system. Help seeking pathways are mainly determined by the perceived causes of illness, which are derived from cultural ideologies. Culture is the lens by means of which people experience, make sense of and react to illness.

The research findings have serious implications for the diagnosis and treatment of illness. These findings shared light into how people perceive and react to illness as well as the process that shape such decisions. If the health providers are not aware of these processes that greatly impacts on the therapeutic alliance and the clinical outcomes.

5.1. Implications for Theory

The research has demonstrated that culture is a major determinant of people's perceptions of illness and how the individuals experience, make sense and react to distress. Irrespective of the cultural, social, political and economic changes in the country, traditional African conceptions of illness are still based on both the traditional African conceptions of the self and its relatedness to its context and the importance of relationships either with nature, the spiritual and natural world, and biological factors. Disturbances in such relationship are perceived to be the major cause of illness. The country needs innovative theories that can capture the South African reality based on people's subjective experiences. This would ensure improved therapeutic alliance and clinical outcomes. Such theories need to consider not just the biopsychosocial model of illness but also the spiritual nature of illness, which is a reality for many Africans. Theory therefore needs to account for these contextual differences. Imposing Western theories in another context without adjusting them for the cultural differences is likely to impact negatively on treatment outcomes, and adherence in particular.

These findings challenge mainstream theories of illness, especially when applied across contexts without acknowledging that there are fundamental differences in ideologies across contexts. The challenge is not only in creating these new theories but a lot needs to be done in exposing practitioners to previously disadvantaged alternative explanations of social realities. This does not only relate to African conceptions; South Africa is a multi-cultural

society that has other races such as the Asian and Chinese and these realities have not been researched and documented.

The findings therefore suggest the need for a more comprehensive cluster of theories that incorporate indigenous knowledge and other alternative explanations. It further highlights the danger of simply importing Western theories and concepts and applying them in other contexts as this serves to maintain the status quo in the country but at the same time inhibits the growth of academic knowledge.

5.2. Implication for Policy and Practice

The research indicates that, although the country is developing and undergoing socio-economic and political changes culture still forms the basis for subjective experience of distress. Culture is the lens through which people interpret and make meaning of their world. Treatment of choice and the therapeutic interaction is also shaped by culture. This creates potential for misunderstanding when the health professional and the client have different cultural background. This may negatively impact on the diagnosis, treatment and the therapeutic outcomes. It is therefore crucial to raise awareness among health professionals about these differences and their potential impact on the clinical outcomes.

Moreover, the research highlights that illness is a social construct that has both spiritual and medical components that require a holistic approach. Health, according to the African conception, is not just the absence of disease; illness has a spiritual aspect that is not diagnosable with Western instruments. This African view of illness therefore requires a holistic and integrated approach that can cater for both the spiritual and the medical element of distress. The relationship between traditional healers and western professionals needs to be strengthened as integration of the two sectors promise holistic treatment. This is not possible at the moment because traditional medicine is not fully acceptable to medical practitioners. Continuous engagement and training between the two sectors is crucial for the management of the dual nature of illness.

Moreover exposure to both systems and a comprehensive syllabus and cultural competence needs to be incooparated into the training of health care professionals. Such knowledge and exposure could possiblely create better understanding on the nature of illness in African

socities and facilitate cross-referrals and the appreciation of the role played by indigenous healers in the management of illness.

5.3. Implication for Future Research

Due to the sample size and the localized context, the research results cannot be assumed to be representative of the Black communities. Further, a much bigger sample could be useful to test the conclusions and findings from these study.The current findings shed some light into areas of further research. These areas would include looking at strategies that can be used in order to ensure an effective integrated health system. Other possible avenues to explore in the future include a qualitative study that would sample a much bigger sample and investigate some of the findings made in this current study. Moreover, further research, especially in the field of psychology, could look at ways which African and Western views on illness can merge to provide appropriate treatment of mental illness. Finally, other possible future studies could be directed at establishing more culture sensitive diagnostic tools that will be more effective in diagnosing across contexts.

5.4. Limitations of the Study

5.4.1. Scope of the study

The study was too broad and as a result did not go in-depth to the lived experiences of the health care users. The study would have been broken into two manageable studies, one on perceptions of health providers and one on the perception of health care users. The size of the study therefore made it complex to focus on finer nuances emerging from each group. The study eventually focused more on health providers because of the richness of the data obatained from this group.

5.4.2. Research instrument

Further the semi-structured questionnairewas not the best option for research instrument to be used in the current study. While the semi-structured questionnaire was expedient, it failed to capture adequately the lived experiences of health care users. However, the data

were useful in that they shaped the interview schedule with the health providers. There were also important insights extracted from that data. A pilot study using the questionnaire would have picked up the problem earlier and the corrective measures would have been taken earlier in the study. After the first batch of questionnaires it became apparent that the quality of the data was not reach enough. In the second batch of interviews more probing was used to yield better quality data. However, a small purposeful sample of health users would have generated good quality data.

5.4.3. Sampling methods

Snowballing was used as sampling technique in accessing the indigenous healers and western-trained psychological counsellors. Most of the health providers sampled had some connection to each other and that could have skewed the research findings. The traditional healers were already part of the integration system that the Department of Health has been advocating. The research findings could have been richer if a representative sample of traditional healers and could have been sampled. On the other hand such a sampling method has been useful in answering questions about their experience with the integrated system.

Moreover, the opportunistic sampling used to sample health care users could have also baised the results and skewed them in the direction of those willing to participate. It was not possible to do random sampling taking into cognizance the resource and the time available to complete the study. However, the data was very useful in not only giving an overview of the health-users perception of illness, perceived cause and help-seeking pathways but also in helping formulate the interview schedule used with traditional healers and psychological counselors.

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APPENDICES

Appendix 1 (a): Information Sheet

Research Aims

The research had aims to investigate perceptions of illness and causes thereof across a selected sample of health care users, traditional healers and western trained counselors. Moreover, the study aims at gaining an in-depth understanding of how traditional healers and western-trained psychological counselors position themselves on western and indigenous conception of illness. Further, the study aims at investigation health users' help seeking pathways and the factors that determine such pathways. Finally, the study aims investigates the attitudes and views of traditional healers and western-counsellors on integrated health system and cross referrals.

Method

The research does not involve any administration of psychological testing. The research will be conducted using a semi structures questionnaire for the patients and their family members and for the health providers an interview schedule will be used.

Duration

The administration of the questionnaire will take approximately sixty minutes and the interviews will take approximately ninety minutes.

Potential risk

The study holds no potential physical, emotional and psychological harm. Should you as a participant experience any harm as a result of the study the researcher will give referrals for assistance.

Potential benefits

The study might not have direct instant benefit for the participants but might benefit future generations should the results reveal the need for interpretative theories of mental illness. The research has more value for the increase in academic and clinical knowledge about the disease in a South African sample and the treatment used by the population for the disease. But also the study might contribute in increasing cross-cultural data in the field of psychology in South Africa.

Confidentiality

Confidentiality will be highly maintained throughout the study. The study requires no personal information that can be traced back to the participants. The only personal information that will be required is the age and gender of the participants. The only people that will have access to the questionnaire are the researcher and the supervisor. The questionnaires will be kept safely for the duration of the study and thereafter destroyed.

In terms of the interview all the taps shall contain no identifying or information that can be traced back to the participants. The tapes will be destroyed after the data has been transcribed. Only the Supervisor and the researcher will have access to the tapes.

Withdrawal

The participants reserve the right to withdraw at any stage should the participant feel uncomfortable.

Dissemination of research results

The results will be reported as a dissertation for a Masters Degree in Psychology. The results will be made available to the academic community. The research results might be published without revealing personal information that can link the participants with the results. The names of the exact communities will not be mentioned but only the region, which is KwaZulu-Natal.

Appendix 1 (b): Information Sheet in IsiZulu

Lokho esifuna ukukuthola ngalelucwaningi

Inhloso yalelucwaningo ukwazi ukuthi abalaphi bendabukho, amakhansela esilungu kanye nomphakathi bacabanga ukuthi kuyini ukugula nokuthi kubangwa yini. Futhi sifisa ukwazi ukuthi abalaphi bendabuko kanye namakhansela esilungu wona amiphi uma kubhekwa indlela i-Afrikha kanye neNtshonalanga ebuka ngayo ukugula. Sifuna futhi ukuthola ukuthi ogulayo uyayeafune kuphi usizo lwezempilo kanti futhi kungani elufuna lapho. Okokugcina sifisa ukuthola uvo lwabalaphi beSintu kanye namakhansela esilungu ukuthi bona bakwamukela kanjani ukusebenzisana kwesintu nesilungu kwezolulapha.

Indlela esizolwenza ngayo lolucwaningo

Angeke sisebenzise ama-psychological test kodwa sizosebenzisa imibuso evulekile kuziguli noma imindeni yazo; sizobese sikhulumisana namakhansela kanye nabalaphi bendabuko.

Isikhathi

Ukuba yinqenye yalolucwaningo kungathatha ihora noma ihora nesigamu.

Ingozi engahle ivele

Lolucwaningo luphephile emzimbeni, emoyeni nasemphefumulweni. Kodwa uma uzwa ngathi likuhlukumezile umcwaningi angakuyalela kwabangakusiza.

Okuhle okungavela kulolucwaningo

Kungenzeka ukuthi wena ungahlomuli okwamanje uma usiza kulolucwaningo kodwa okuyotholakala ngosizo lwakho kungasiza izizukulwane ezizayo emkhakheni wezokulapha. Futhi umphumela ungandisa ulwazi olukhona ezikhungweni zemfundo kanti futhi lungasiza ngendlela ekusetshenzwa ngayo kwezempilo. Ulwazi lungaziza ukwandiswa ulwazi ngezinye izinhlanga eMzansi Afrika ebezicindezelwe ngaphambili.

Ukuvikeleka kwemininingwane yakho

Lelicwaningo alidingi minininingwane yakho engenza ukuthi abantu bazi ukuthi utheni. Imininingwane esiyidingayo wukuthi uneminyaka emingaki nokuthi ongobuphi ubulili.

Imininingwane yakho kanye nokushoyo kuyimfihlo kulolucwaningo. Babili kuphela abantu abazokwazi ukulalela nokufunda esizokuxoxa, umcwaningi nothisha wakhe. Lamakhasede kanye nama-questionnaires azobekwa endaweni ephephile ngenkathi kuqhutshekwa kwenziwa uchwaningo emva kwalokho ashiswe.

Uma ufuna ukuyeka

Unelungelo lokuyeka ukuba yingxenye yaleli-cwaningo uma usizwela ngathi usufuna ukuyeka noma ungaphathekile kahle.

Imiphumela yocwaningo

Imiphumela kocwangiso izosetshenziselwa ukuthola iziqu semfundo ephakeme kwi-Psychology. Imiphumela izokwazi futhi ukufundwa umphakathi wezemfundo. Kungenzeka futhi imiphumela papashwe kodwa angeke idalule imininingwane ephathelene nawe. Imininingwane engasentshenziswa wukuthi lokucwaningo lwalwenziwe KwaZulu-Natal.

Appendix 2 (a): Consent Form

Purpose

The research had aims to investigate perceptions of illness and causes thereof across a selected sample of health care users, traditional healers and western trained counselors. Moreover, the study aims at gaining an in-depth understanding of how traditional healers and western-trained psychological counselors position themselves on western and indigenous conception of illness. Further, the study aims at investigation health users' help seeking pathways and the factors that determine such pathways. Finally, the study aims investigates the attitudes and views of traditional healers and western-counsellors on integrated health system and cross referrals.

Data Collection

The research does not involve any administration of psychological testing. The research will be conducted using a semi-structured questionnaire for the patients and their family members. An interview schedule will be used to interview the health providers.

Confidentiality

Confidentiality will be highly maintained throughout the study. The study requires no personal information that can be traced back to the participants. The only personal information that will be required is the race, age, and level of education and gender of the participants. The only people that will have access to the questionnaires and the tapes are the researcher and the supervisor.

Feedback

Should the participant require feedback about the findings, verbal feedback can be arranged with the researcher. The study might be published.

Harm

The study holds no potential physical, emotional and psychological harm. Should you as a participant experience any harm as a result of the study the researcher will give referrals for assistance.

I ……agree to participate in the study about perceptions of illness. I understand that my participation is voluntary. I have the right to withdraw from the study should I feel uncomfortable at any stage in the research. All the above information has been explained to me.

……. ……. …….

Participants' name Signature Date

Appendix 2 (b): Consent Form in IsiZulu

Lokho esifuna ukukuthola ngalelucwaningi

Inhloso yalelucwaningo ukwazi ukuthi abalaphi bendabukho, amakhansela esilungu kanye nomphakathi bacabanga ukuthi kuyini ukugula nokuthi kubangwa yini. Futhi sifisa ukwazi ukuthi abalaphi bendabuko kanye namakhansela esilungu wona amiphi uma kubhekwa indlela i-Afrikha kanye neNtshonalanga ebuka ngayo ukugula. Sifuna futhi ukuthola ukuthi ogulayo uyayeafune kuphi usizo lwezempilo kanti futhi kungani elufuna lapho. Okokugcina sifisa ukuthola uvo lwabalaphi beSintu kanye namakhansela esilungu ukuthi bona bakwamukela kanjani ukusebenzisana kwesintu nesilungu kwezolulapha.

Indlela esizolwenza ngayo lolucwaningo

Angeke sisebenzise ama-psychological test kodwa sizosebenzisa imibuso evulekile kuziguli noma imindeni yazo; sizobese sikhulumisana namakhansela kanye nabalaphi bendabuko.

Ukuvikeleka kwemininingwane yakho

Lelicwaningo alidingi minininingwane yakho engenza ukuthi abantu bazi ukuthi utheni. Imininingwane esiyidingayo wukuthi uneminyaka emingaki nokuthi ongobuphi ubulili. Imininingwane yakho kanye nokushoyo kuyimfihlo kulolucwaningo. Babili kuphela abantu abazokwazi ukulalela nokufunda esizokuxoxa, umcwaningi nothisha wakhe. Lamakhasede kanye nama-questionnaires azobekwa endaweni ephephile ngenkathi kuqhutshekwa kwenziwa uchwaningo emva kwalokho ashiswe.

Ukuthola ulwazi ngemiphumela

Uma udinga ukwazi ukuthi impiphumela yocwaningo yahamba kanjani unelungelo lokuqhumana nomcwaningi nihlele ukuthi nixoxisane ngawo.

Mina ……ngiyavuma ukuba ngibeyinxenye yalocwaningo olumayelana nokuthi kuyini ukugula. Ngiyazi ukuthi angiphoxiwe ukuba yingxenye yocwaningo. Nginelungela lokuyeka uma ngizizwela ukuthi angisafuni ukuba yinqenye yalolucwaningo. Yonke lemininingwane ngiyiqhazelwe.

……. ……. …….

Igama lakho Sayina Ilanga

Appendix 3: English Questionnaire

INTRODUCTION

Thank you for agreeing to talk about your health. I would like to ask some questions about your health and how it affects you. The questions have already been written out so it will sound like a normal interview and some things may not have do with your situation. I would like to stress that all your answers will be strictly confidential.

1. 1-3	Record number		Rec
1. 4-9	Date of interview		Seen
1.10	Gender		Sex
1.11 -12	Age		Age

2. HEALTH & ILLNESS: CURRENT HEALTH SYSTEM:

(a). Have you been to this facility before? If yes, what was it about?

_____

_____

_____

(b)Now what have you come here for? List up to 3 reasons

2.1- 2.2		Problem1
2.3-2.4		Problem2
2.5-.26		Problem3

HEALTH OVER LAST YEAR

(c) Over the past year have you had any illness or health problems?

2.7- 2.8		Year1
2.9- 2.10		Year2
2.11 – 2.12		Year3

(d) What do you call these problems? Probe: If you had to give them a name what would they be?

2.13- 2.14		Name1
2.15 -2.16		Name2
2.17 – 2.18		Name3

(e) When did you first notice the identified problems: (Probe how long ago was it, when did it start?)

2.19 - 2.20		Onset1
2.21- 2.22		Onset2
2.23- 2.24		Onset3

(f) Why do you think these problems started when they did? Let us take one problem at a time, starting with (name problem).

2.25 - 2.26		Why1
2.27 -2.28		Why2
2.29 – 2.30		Why3

3. **PERCEIVED SEVERITY**

a. How serious are your problems?

3.1		Serious1
3.2		Serious2
3.3		Serious3

b. What do you most fear about these problems?

3.4		Fear1
3.5		Fear 2
3.6		Fear 3

c. Why did you go to the traditional healer/doctor/psychologist/psychiatrist? Were you afraid of what the illness might be? Did other people advise you to go?

_____

_____

_____

4. EXPECTATION OF/ SATISFACTION WITH TRADITIONAL/MEDICAL

a. What do/did you hope to gain from seeing your traditional healer/doctor/psychiatrist or psychologist? What do/did you want them to do?

4.1	Expectation1
4.2	Expaectation2
4.3	Expectation3

b. Have you asked your traditional healer/doctor/psychiatrist or psychologist about these problems?

_____

_____

c. What did they do about these problems?

4.5		Gpact1
4.6		Gpact2
4.7		Gpact3

d. Was it useful talking to the traditional healer/doctor/psychiatrist or psychologist about the problem? Can you say why?

_____

_____

_____

e. Was there anything about your treatment you are unhappy about?

_____

_____

_____

5. ACTIVITIES AND FUNCTIONING

a. What are the main difficulties your problems have caused you (List 3)

5.1- 5.2		Disf1
5.3- 5.4		Disf 2
5.5- 5.6		Disf 3

b. Which parts of your body are most affected by your problems? (List 3)

5.7		Body1
5.8		Body2
5.9		Body3

c.How have you been affected emotionally by what you've described (give example)_____

_____

_____

d.Have these problems stopped you getting about as well as you used to?

_____

_____

_____

e. Have these problems affected your social life? (Give example)

_____

_____

_____

f. Have these problems affected your home life? (Give examples)

_____

_____

_____

g. Have these problems affected how you get on with people in general (give example)

_____

_____

_____

h. Has your work been affected (how?)

_____

_____

_____

6. **OTHER HEALTH BEHAVIOURS**

a. Have you asked advice from anyone else about the problem? Probe hospital, pharmacist, friends, family, church, and healers?

_____

_____

_____

b. Has anyone else apart from your doctor given you any medication or advice about this?

_____

_____

_____

c. Are you treating yourself for the problem?

_____

_____

_____

d. If so how?

_____

_____

_____

e. Are you taking medication? (What is it?) This includes prescriptions by the Traditional healers.

6.5 – 6.6		Meds1
6.7 – 6.8		Meds2
6.9 – 6.10		Meds3

f. Are you taking any other cures or remedies?

_____

_____

_____

Now I am going to read you a short story. Please listen carefully because when I am finished, I want you to discuss with me some issues related to the story. Can I start or do you want to ask some questions?

Case Study One

Thabo is a 17-year-old boy that belonged to a Zion Christian Church. His mother reports that at the church service Thabo just stood up and began shouting and preaching. The following day Thabo was excitable and continued to pray. He could not sit still and talked and sang all day long. He also started being agitated and slept less and was not tired as a result of that. Thabo reported that he was receiving messages from Jesus, his Lord and Saviour. Thabo at night would wake up and report that he had had a dream about his late grandfather calling him.

1. What if anything, was the case with Thabo?

_____

_____

_____

2. Does he have an illness? If yes, what is it?

_____

_____

_____

3. What are the causes of his experiences/situation?

4. What should he do about it? And why?

5. What should the doctor/ traditional healer/ psychiatrist or psychologist do about it?

Case Study two

Mr. Khumalo is a 34 –year-old married man. He has been unable to get onto a taxi since his friend was killed in the taxi violence. He has not been going to work for four months because of the fear of the taxis. His family is now in a financial crisis since he is no longer getting a salary. Mr. Khumalo now spends most of his time at home. Whenever he is in a crowd he starts sweating and feels tense and panicky. He suspects that something bad will happen to him. So to avoid these feelings he prefers to stay indoors.

1. What if anything was the case with Mr. Khumalo?

2. Does he have an illness? If yes, what is it?

3. What are the causes of his experience/situation?

4. What should he do about it? And why?

_____

_____

_____

5. What should the doctor/ traditional healer/ psychiatrist or psychologist do about it?

_____

_____

_____

Case Study three

Mr. Mahlangu is twenty years old and single. He recently lost his father in motorcar accident. Since the death of his father, he has been a loner and no longer wants to socialize with his friends. He feels somewhat responsible for the death of his father and cries a lot. He has recurrent dreams about his father. Mr. Mahlangu reports to lack the energy to wake up in the morning and says that he spends his day in bed. He sometimes sees life as not worth living. He reports that he is feeling quite sick but the doctor says that there is nothing wrong with him. When the doctor told him that he was not sick he went to another doctor who also told him that there was nothing wrong with him

1. What if anything was the case with Mr. Mahlangu?

_____

_____

_____

2. Does he have an illness? If yes, what is it?

_____

_____

_____

3. What are the causes of his experience/situation?

_____

_____

_____

4. What should he do about it? And why?

_____

_____

_____

5. What should the doctor/ traditional healer/ psychiatrist or psychologist do about it?

_____

_____

_____

Case Study Four

Bongane, a thirty two year old gentleman left home to Johannesburg to seek employment. He had left school in Grade seven (standard five). He hoped to get domestic work in one of the towns in Johannesburg. On his arrival there he had no relative or friends. He slept on the streets for a couple of days until he found a part time job. After a few weeks his employer dismissed him. He had no choice but to go back home. At home both his parents had died and he therefore had to stay with his aunt. His aunt repeatedly remaindered him that he was useless and did not have a source of income at his age. His uncle at the same time nagged him about the fact that he had not gone to the mountain to be circumcised. The grandmother from the next door suggested that Bongane could have been bewitched and that would explain all his misfortunes. Bongane was deeply hurt by his aunt's and uncle's comments and he started feeling hopeless and helpless. At the same time Bongane started to complain about pains all over his body.

1. What if anything was the case with Bongane?

_____

_____

_____

2. Does he have an illness? If yes, what is it?

_____

_____

_____

3. What are the causes of his experience/situation?

_____

_____

_____

4. What should he do about it? And why?

_____

_____

_____

5. What should the doctor/ traditional healer/ psychiatrist or psychologist do about it?

_____

_____

_____

Appendix 4: Zulu Questionnaire

Isingeniso

Ngiyabonga ukuvuma kwakho ukukhulunisana nami ngempilo yakho. Kubalulekile ukuthi wazi ukuthi konke esizokukhuluma kuyimhlihlo phakathi kwami nawe.

1. 1-3	Record number		Rec
1. 4-9	Usuku		Seen
1.10	Ubulili		Sex
1.11 -12	Iminyaka		Age

2**. Isimo sakho sezempilo:**

(a). Uke weza yini lapha ngaphambilini? Kwakwenzenjani?

_____

_____

_____

Namhlanje uze ngani? Nginike izimpendulo ezingecile kwezintathu.

2.1- 2.2		Problem1
2.3-2.4		Problem 2
2.5-.26		Problem3

Impilo yakho onyakeni odlule

(b) Onyakeni odlule ukewagula? Ngiphe izifo ezintathu ezazikuphethe.

2.7- 2.8		Year1
2.9- 2.10		Year2
2.11 – 2.12		Year3

(c) Ungazibiza ngokuthi ziyini lezizinkinga na? Uma ubune gama ongazibiza ngazo bewungathi yini?

2.13- 2.14		Name1
2.15 -2.16		Name2
2.17 – 2.18		Name3

(d) Waqala nini ukubona izimpawu zalezinkinga na? Kwakuyisikhathi esingakanani esadlula?

2.19 - 2.20		Onset1
2.21- 2.22		Onset2
2.23- 2.24		Onset3

(e) Ucabanga ukuthi kungani lezizinkinga siqale ngalesisikhathi eziqale ngaso? Asizibuke ngenye emva kwenye siqalenge:

2.25 - 2.26		Why1
2.27 -2.28		Why2
2.29 – 2.30		Why3

3. **Ucabanga ukuthi ugula kangakanani?**

a. Ucabanga ukuthi lezizinkinga zinkulu kangakanani?

3.1		Serious1
3.2		Serious2
3.3		Serious3

b. Kuyini okwesaba kakhulu mayelana nalezi zinkinga?

3.4		Fear1
3.5		Fear 2
3.6		Fear 3

c. Kungani uvakashele umlaphi wendabuko/ noma dokotela /noma psychologist noma ipsychiatrist ? ube unovalo ukhuthi zingayini lezizinkinga? Kukhona yini abakweluleka ngalezizinkinga?

_____

_____

_____

4 . Imizwa yakho ngosizo olutholile

a. Kuyini loku ubunethemba lokukuthola emva kokuvakashela umlaphi wesintu/ dokotela /psychologist noma ipsychiatrist? Ubunesifiso sokuthi akwenzeleni?

4.1		Expectation1
4.2		Expaectation2
4.3		Expectation3

b. Ukewacela ukululekwa ku umlaphi wesintu/ dokotela /psychologist noma ipsychiatrist mayelana nalenkinga?

_____

_____

_____

c. Yini ayenza ukukusiza ngalenkinga?

4.5		Gpact1
4.6		Gpact2
4.7		Gpact3

d. Kwaba lusizo yini ukukhuluma no umlaphi wesintu/ dokotela /psychologist noma ipsychiatrist ngalezizinkinga? Ungasho ukuthi ukusho ngani lokho?

_____

_____

_____

e.Kukhona yini ongakuthokozelanga ngendlela ukulapha ngayo noma ngemithi akunika yona ukubhekana nalezizinkinga?

_____

_____

5. Impilo yakho yansuku zonke.

a. Ngesikhathi uphethwe yilezizifo yiziphi izinkinga owadlangabezana nazo empilweni yakho? Nginike ezintathu.

5.1- 5.2		Disf1
5.3- 5.4		Disf 2
5.5- 5.6		Disf 3

b. Yimaphi amalunga ozimba wakho ahlukumezeka ngenxa yalezi zinkinga? Nginike amathathu.

5.7		Body1
5.8		Body2
5.9		Body3

c. Lezizinkinga ziwuhlukumeze kanjani umoya wakho? Ngiphe isibonelo?

_____

_____

_____

d. Zikwenzile yini ukuba ungasakwazi ukuya lapho ubuthanda ukuya khona?

_____

_____

_____

e. Ziyishintshile yini indlela oxhumana ngayo nabanye abantu? Ngiphe isibonelo.

_____

_____

_____

f. Ziyishintshile yini indlela ophilisana ngayo nabantu ekhaya? Ngiphe isibonelo.

_____

_____

_____

g. Ziyishintshile yini ubudlelwane bakho nabanye? Ngiphe isibonelo.

_____

_____

_____

h. Umsebenzi owenzayo uhlukumezekile yilezizinkinga na? Uhlukumezeke kanjani?

_____

_____

_____

6. Eminye imibuzo mayelana nempilo yakho

a. Uke wacela ukululekwa yilaba abalandelayo: udokotela, osokhemisi, abangani, esontweni noma emdenini ngalezizinkinga?

_____

_____

_____

b. Kukhona yini ngaphandle kukadokotela ukonike imithi yalezizinkinga?

_____

_____

_____

c. Ukewazilapha wena ngalezizinkinga na?

_____

_____

_____

d. Uma kunjalo wazilapha kanjani?

_____

_____

_____

e. Kukhona imithi oyisebenzisayo na? Ubizwa ngokuthi iyini? Ungabala nemithi oyiphiwe umlaphi wesintu..

6.5 – 6.6		Meds1
6.7 – 6.8		Meds2
6.9 – 6.10		Meds3

f. Kukhona yini eminye imithi uyisebenzisayo?

_____

_____

_____

Manje ngizokufundela indaba emfushane. Ngicela ulalele kahle ukuze ungiphendule kulemibuzo engiyokubuza yona emayelana nayo lendaba engizokufundela yona. Lalelisisa ke. Sengingaqala? Unayo yini imibuzo ngaphambi kokuba ngiqale?

Indaba yokuqala

Thabo uyinsizwa eneminyaka engu 17. Uyilunga le Zion Christian Church. Umama wakhe uthi u Thabo esontweni uvese wasukuma waqala wamemeza eshumayela. Ngosuku olulandelayo uThabo ubenjabulo enkulu eqhubeka ethandaza. Ube hluleka ngisho nokuhlala phansi ekhulume njalo usuku lonke. uThabo ubeseqala nokungalali ubusuku kodwa angazizwa ekhathele emini. Uthabo washo nokusho ukuthi uzwa uJesu ekhuluma naye. Ebusuku bangalelo langa Uthabo wavuka nephupho ephupha umkhulu wakhe osowashona embiza.

1. Ubenani uThabo umangabe bekukhona okungalungile ngaye?

_____

_____

_____

2. Unesifo thizeni yini uThabo? Umakunjalo, Siyifiso sini?

_____

_____

_____

3. Sibangwe yini lesisimo sikaThabo?

_____

_____

_____

4. Kufanele Uthabo enzeni mayelana nalesisimo? Kungani ucabanga kanjalo?

_____

_____

_____

5. Kumele udokotela/ umlaphi wesintu/psychologist noma ipsychiatrist yenzenjani ngesimo sikaThabo?

_____

_____

_____

Indaba yesibili

UKhumalo ungumnunzane oshadile oneminyaka ewu 34. uKhumalo useyasaba ukuhamba ngamatekisi emva kokudutshulwa odlameni lwamatekisi. Ngenxa yalokho akasakwazi nokuya emsebenzini. Umdeni wakhe usesimeni usibuqayi nayelana nezimali futhi ngoba engasawutholi umholo. UKhumalo esikhathini esiningi usehlala esekhaya ezivalele. Njalo uma ethi uya esixukwini sabantu uvele aphathwe ukwesaba okukhulu ajulike abemanzi. Esixhukwini ubanokwesaba ukuthi kungaba khona into embi engamehlela. Ukuvimba konke lokho usekhethe ukuzihlalela ekhaya angayindawo.

1. Ubenani uKhumalo uma ngabe bekukhona ekungalungile ngaye?

_____

_____

_____

2. Unesifo thizeni yini uKhumalo? Umakunjalo, Siyifiso sini?

_____

_____

_____

3. Sibangwe yini lesisimo sikaKhumalo?

_____

_____

_____

4. Kufanele UKhumalo enzeni mayelana nalesisimo? Kungani ucabanga kanjalo?

_____

_____

_____

5. Kumele udokotela/ umlaphi wesintu/psychologist noma ipsychiatrist yenzenjani ngesimo sikaKhumalo?

_____

_____

_____

Indaba yesithathu

Umnumzane uMahlangu eneminyaka ewu20 akashadile. Usanda kulahlekelwa ubaba wakhe engozini yemoto. Kusukela ukushoneni kukababa wakhe usehlezi eyedwa futhi akafuni ukuphuma nokuxoxa nabangane bakhe njengakuqala . Uzizwa enecala ngokushona kukababa wakhe lokhu kumenza ukuthi ehlezi ekhala. Uthi uhlezi ephupha ngobaba wakhe. Usho nokusho ukuthi akasanawo nomdlandla wokuvuka embhedeni njalo ekuseni yikho ehlezi elele. Impilo ayisekho mnandi ukuba aqhubeke ngokuphila. Uthi uzizwa egula kodwa udokotela uthi akanalutho. Useye nakudokotela wesibili omtshele khona lokho ukuthi akaboni lutho olungalungile emzimbeni wakhe.

1. Ubenani uMahlangu uma ngabe bekukhona ekungalungile ngaye?

_____

_____

_____

2. Unesifo thizeni yini uMahlangu? Umakunjalo, Siyifiso sini?

_____

_____

_____

3. Sibangwe yini lesisimo sikaMahlangu?

_____

_____

_____

4. Kufanele UMahlangu enzeni mayelana nalesisimo? Kungani ucabanga kanjalo?

_____

_____

_____

5. Kumele udokotela/ umlaphi wesintu/psychologist noma ipsychiatrist yenzenjani ngesimo sikaMahlangu?

_____

_____

_____

Indaba yesine

UBongane uyinsizwa eneminyaka ewu32 eyahamba akhaya ilibangisa eGoli ukuyofuna umsebenzi. Wayeka esikoleni kwa Grade7 (Ibanga lesihlanu). Wayenethemba lokuthola umsebenzi ejalidini kwelinye lamadolobha asegoli. Ekufikeni kwakhe eGoli wayengenamngani noma isihlobo khona. Walala emgwaqeni izinsukwana efuna umsebenzi. Emva kwezinkukwana wathola umsetshenzana waphinde waqoshwa kuwona kungekudala. Wanquma ukubuyela ekhaya. Emuva ekhaya umama nobaba besebedlula emhlabeni. Ubabekazi nomalume wakhe babemkhumbuza njalo ukuthi akalutho futhi uyisehluleki. Umalume ayekhumbuza nokuthi futhi ubengayanga ukuyosokwa njengabanye abafana. Ugogo wakwamakhelwane wabanombono wokuthi uBongane uloyiwe yikho ezinto zazenzeka ngaleyandlela empilweni yakhe. UBongane walimala kakhulu emphefulweni wakhe elimazwa ubabekazi nomalume waqala wazizwa engeluthu futhi enganathemba. uBongane waqala ukusho ukuthi umzimba wakhe ubuhlungu.

1. Ubenani uBongane uma ngabe bekukhona ekungalungile ngaye?

_____

_____

_____

2. Unesifo thizeni yini uBongane? Umakunjalo, Siyifiso sini?

_____

_____

_____

3. Sibangwe yini lesisimo sikaBongane?

_____

_____

_____

4. Kufanele uBongane enzeni mayelana nalesisimo? Kungani ucabanga kanjalo?

_____

_____

_____

5. Kumele udokotela/ umlaphi wesintu/psychologist noma ipsychiatrist yenzenjani ngesimo sikaBongane?

_____

_____

_____

Appendix 5: Interview Schedule with Traditional Healers

1. When did you become a traditional healer?
2. How did you know you were called? What form of training did you receive?
3. What are some of the memorable experiences that you have had in this healing profession? Give examples.
4. What type of people do you normally see? Give example.
5. How do you define illness and what do you perceive to be the cause of ill health?
6. What method do you use to diagnose your patient and what role is played by the diagnosis?
7. Do you ever refer your clients to other health providers? And why? To whom do you refer?
8. Can traditional healer work concurrently with western trained health providers?

Appendix Six: Interview Schedule with African Western Trained Health Professionals

1. Being an African do you find yourself feeling conflicted between your African views and that of the West that you have been exposed to in your training?

2. As an African who has had western training how do you understand the concept of illness?

3. What do you think actually cause illness both physical and mental illness?

4. What are some of the challenges that you perceive in treating indigenous people in a western model? And how do you manage them?

5. South Africa is advocating for an integrated health system that will include both African and western trained professionals. What are your views about that?

6. Is your work informed by indigenous or western knowledge system? Do this conflict with each other?

7. Is your life more influenced by African values or Western values?

8. What value does indigenous healers in modern South Africa and in the future?