BELIEFS AND PRACTICES IN MENTAL ILLNESS IN A RURAL AND URBAN SAMPLE OF AFRICAN PEOPLE

BY

MELAMU MAC - FALLEN SHUPING

Submitted in part fulfilment of the requirements for the degree of Master of Social Science (Clinical Psychology) in the Department of Psychology in the Faculty of Social Sciences at the University of North-West.

SUPERVISORS: MR. Q. TEMANE

MRS. V. SEGAMI

DEDICATION

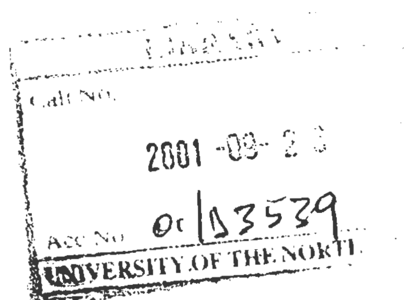
To my mother MATSÊLISO THELMA SHUPING

A devoted persevering mother and a source of inspiration

And

To my sister MOLEHALI MURIEL MALLANE

My pillar of strength and support.



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DECLARATION

I declare that the dissertation for the degree of Master of Social Science (Clinical Psychology) in the Department of Psychology in the Faculty of Social Sciences at the University of North-West hereby submitted, has not previously been submitted by me for a degree at this or any other University, that it is my own work in design and execution and that all material contained herein has been duly acknowledged.

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ABSTRACT

A survey type to explore the beliefs and practices of African people in mental illness was carried out. The aim of the study was to assess the beliefs and practices with a view to establish the need for integrating traditional African healing system with Western healing system.

A sample of thirty 32 black participants were selected by means of a cluster sampling technique, in which fifty percent of the sample were from the rural area and the other fifty percent were from the urban area. Half of the sample was females, and the other half was males. Respondents were drawn from Mafikeng and surrounding villages of the north-west Province.

Data was collected through semi-structured interviews. Respondents were interviewed according to the standardised interview questions. Responses were content analysed into themes and descriptive techniques were used. Chi-square tests were used to determine the significant differences in relation to sociodemographic factors.

The main finding of the study was that, the African Black population in general, has more positive beliefs towards both traditional and Western healing systems jointly. A majority of respondents favoured the merger between the two healing systems. There were no significant difference in beliefs and practices in relation to sociodemographic factors, of the sampled population. A large percentage of respondents showed a full confidence in the capabilities of traditional healers in treating different illnesses particularly mental illness. The need for the traditional healers to be recognised and to be made part of the official health care system in South Africa cannot therefore be over-emphasised, so that the universal goal of “health for all” could be realised.

CHAPTER ONE

1. BACKGROUND INFORMATION

1.1 INTRODUCTION

Within Psychology and related disciplines, probably the worst pressing tasks are to plan and develop structures and mechanisms which will ensure appropriate and acceptable mental health for all (Freeman, 1991). Indeed the present focus in South Africa on primary health care, increases the need to deliver an efficient affordable, equitable health system to all without discrimination; so that the universal goal of "health for all" could be realised.

The beliefs and practices of communities regarding mental health and illness are crucial in developing these structures and mechanisms. Hence the present study will emphasise attempts of making this information manifest. Thus the present study will be an attempt to bring the two divergent systems of health care closer in their delivery of mental health care.

The philosophical question of relationship between belief and practice can be compared to the social-psychological conundrum of attitudes-beliefs- practice. The effective implementation of any new system, hybrid or otherwise, requires baseline information to be collected. In this case, the beliefs of rural people about the causes of mental illness and its care, could play a pivotal role in drawing traditional healers into the mainstream health care facilities.

In South Africa, two basic systems of health operate side-by-side, that is, the indigenous traditional healing system and the Western (bio-medical) medicine. For the most part however the Western and Traditional systems of health care operate independently with "consumers" choosing whom to consult (Freeman & Motsei, 1992; Hopa, Simbayi and Du Toit, 1997). Although Western healing is popular and informs the layman's definition of health, traditional healing still permeates all aspects of African life.

The current political changes in South Africa and the realisation that there is a need to transform many institutions have resulted in strident

calls for change to mental health (Pillay & Petersen,1996) and specifically to health care delivery. These changes should enjoy the support of all interested constituencies, like consumers of these services, which include both rural and urban inhabitants. Within health care, especially in cases of mental health, this transitional phase offers the opportunity to debate and develop approaches which will provide adequate and appropriate health care for all.

It is useful to explore the utilisation of both systems of medicine. This is particularly necessary in South Africa, where two systems operating in parallel fashion, will need to function in a more integrated manner if the mental health needs of the population are to be effectively cared for in the future; So that a sound co-operation can be encouraged, and thus Africans can utilise the most effective health care services for different conditions and under differing circumstances.

A lot more research is being done lately on the attitudes and perceptions of health practitioners towards Traditional and Western medicine. The present study will try to focus more on the communities beliefs and

practices towards these two health systems, in cases of mental illness (psychopathology), with a view of looking at the possibility of merging the two systems for better mental health care of the entire population.

In the study, the target group will be the Black population in and around Mafikeng, thus emphasis will also be put on the role of indigenous healers in mental health field in these societies. Snyman (1992) maintains that, the utilisation of traditional medicine deserves consideration because of the approval of the World Health Organisation (WHO) and the South African government on the one hand, and the extent of acceptability of this type of medicine for a larger proportion of the Black population on the other. This research will help to reflect a world-wide impetus towards making health accessible, affordable, accountable and more importantly culturally relevant for all people.

According to the National Health Plan of 1994; The challenge facing South Africa, amongst others, is to design a comprehensive programme to redress social and economic injustices. In the health sector, this will involve the complete transformation of the national health care delivery

system and all relevant institutions. The legacy of apartheid policies in South Africa has created large disparities between racial groups in terms of socio-economic status, occupation, education, housing and health. These policies have created a fragmented health system, which has resulted in inequitable access to health care, particularly for the black indigenous societies.

Shortcomings in the prevailing South African mental health services have been pointed out by various prominent South African Psychiatrists and Psychologists, who have appealed for greater recognition to be given to and for greater use to be made of the skills of indigenous healers in treating persons who may benefit from their services (Hold stock, 1979; Wessels, 1985; Edwards, 1985). At present in South Africa, referral which does occur is overwhelmingly from Traditional healing to Western medicine. Reasons for this include the deep suspicion which most Western practitioners have for traditional healing.

Agents of mental health in South Africa range from the traditional (e.g. indigenous healers) to the Western (e.g. Psychiatrists). The present

government is of the view that, there be an integration of these systems into the National Health System (NHS), which in a practical sense, is seen to be slow. Van Rensburg and Mans (1982) argue that, the present supply of health care in South Africa can decidedly not always be reconciled with the actual demands or needs of the population; in fact the existing distribution of health services and facilities, as well as the priorities apparently recognised at present, definitely tend to be relatively favourable for specific population groups or population segments and for specific patient and disease categories.

Findings in the research done by Pillay and Petersen (1996), suggests that the White urban population has relatively greater access to the services of clinical and counselling Psychologists than Black and rural communities.

Language and cultural differences render the services of the majority of Psychologists even more inaccessible to the bulk of the population of the country who are not first-language English or Afrikaans speaking. This imply that, the mental health services are still not equitable for the South

African population, especially the Black population. However, more South African situation is characterised by a sharp contrast in the parallel existence of two distinct systems of health care; In some cases supplementary, but usually in a neutral or clashing relationship (Van Rensburg & Mans, 1982). As Pillay (1996) has noted that, in the complex society that is South Africa today, a highly sophisticated technological medical system co-exists with traditional beliefs and practices concerning health and ill health. However Makwe (1985) is of the view that, the two systems of treatments of mental illness are essentially similar, differing only in superficial respects. Janzen (1978) as cited by Wajsman (1986), showed that the two systems are practised alongside one another and that a client makes use of both methods, depending on his needs.

According to Henn (1990) there is enough evidence in the literature that African health and illness concepts in contemporary society incorporate both traditional African and Western biomedical views. There is evidence that what we view as "physical illness" is often interpreted in terms of Western biomedical concepts while "psychiatric illness" is often

explained in traditional terms. It was found that patients in South Africa choose their healers according to the disease they have (Fenyves, 1994). Some can only be treated by Western healers, others are only treatable by indigenous healers.

Practice of traditional medicine and traditional healing in Africa dates back to ancient times. These practices continue even to the present times, both in urban and rural areas (Ramokgopa, 1993). Since the collapse of colonialism, the African sociocultural identity has slowly been revived and with it traditional medicine as part of that cultural heritage. As the study is conducted from the black indigenous population, emphasis will be put on the importance of indigenous healers to the mental health field in indigenous societies.

As Tsey (1997) has emphasised, the fundamental assumption underpinning the discourses on traditional medicine, is the view that the trade should be taught and practised as part of formal health care sectors. This will further ensure that the provision of mental health care in South Africa, really lends itself to an appropriate and a fair distribution

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which in commensurate with the actual health needs of the population. By investigating the beliefs and practices of the community about mental illness, will help in ascertaining these views and assist in further evaluating the efficacy of the present mental health care system, particularly in the South African context.

1.2 PROBLEM STATEMENT

South Africa is in the process of dramatic social and political change, this presents challenges to people in every sphere of society to re-evaluate their conceptions and practices, and examine possibilities for the future (Freeman, 1991). The focus here, basically is on the utilisation of mental health services (both Western and/or Traditional), from the consumer's point of view, as well as to hear their opinions on the merging of these two health services.

The study appropriately interrogates the belief system of ethnic community in relation to the causes and appropriate treatment of mental illness. A survey of the choices of people and their perceptions of various healers, what they believe or think about them and generally how

they view different healers is pertinent. Thus the major question is what are their conceptualisation of mental illness and their consultation patterns in regard to these disorders.

1.3 SIGNIFICANCE OF THE STUDY

The study will seek to explicate the beliefs of consumers of health care in regard to practice and opinions on the merging of Traditional and Western modes of heath care (Stones, 1996). We must therefore have knowledge of consumer's beliefs about the cause of their problems and consider what implications such beliefs might have for service provision (Maclachlan, et al. 1995).

The study will also assist in providing a profile about the people's explanations about the causes of their mental health problems and consider what implications such beliefs and explanations might pose for the mental health provision. Adequate knowledge of the communities attitudes and health practices, is necessary for clinicians who have to deal with the ever-increasing psycho-social illness in the African population.

The previous studies indicated that the traditional African health practices still thrive in South Africa. In view of this resilience of a practice that is deeply rooted in the culture of the indigenous people of South Africa, the present study will make the mental health professionals aware of the utilisation and importance of traditional healers within the community and enhance the speedy and practical co-operation of traditional healing in the formal National Mental Health Care System.

Sodi (1987) maintains that, Western-oriented health professionals have generally neglected the cultural background underlying some mental illnesses among Africans, which makes their intervention less effective within the African context. It was on the same breath that practices of indigenous healers have been dismissed as primitive, retrogressive and dangerous. This ethnocentric bias has had a number of implications on the delivery of health care in Africa, particularly in South Africa.

By developing a profile of attitudes from the community regarding the efficacy of treatments and interventions in cases of mental illness will help to enhance the appropriateness of delivery of mental health care in

South Africa. This study will also highlights some of the key issues which policy makers may wish to explore with regard to the future of traditional medicine in South Africa and other African countries.

The study also behoves health professionals to examine the strengths and weaknesses of traditional medicine, so that they can promote its strengths and discourage its weaknesses for the benefit of the people who believe in it and utilise it (Airhinhenbuwa, 1995). Lastly the study will help to highlight the role and utilisation of traditional healers in the greater Molopo district. Any influence brought about by social characteristics such as sex, demographic locality and age differences in beliefs (perceptions) and practices of people regarding mental health and ill health, will also be studied.

1.4 MOTIVATION OF THE STUDY

In South Africa, as elsewhere in Africa, traditional medicine is an explorable alternative. Its utilisation is worth considering, not only by virtue of its approval by the World Health Organisation but also by virtue of the high degree of acceptance of, general demand for and

consumption by a large portion of the Black population in South Africa (Van Rensburg, Fourie and Pretorius, 1994).

Modern mental health medical and para-medical professionals, in particular, have urged for more national integration of the two health systems, with the view that indigenous healers have an important role to play, particularly in the fields of Psychology and Psychiatry (Rappaport & Rappaport, 1981). Hence the motivation to ascertain the utilisation of these two systems by the Black population.

The study is partly motivated by the recent world-wide resurgence of interest in traditional medicine and indigenous knowledge systems in general. On another level, black economic empowerment, the Afrocentric- Eurocentric debate and the African renaissance are subjects which have crept into the South African national agenda.

Van Rensburg et al. (1994) affirmed the fact that, assumptions about and condemnation of traditional medicine are often made without substantial proof or an in-depth analysis. My experience as a clinical

intern, showed that many patients who consulted at the unit, reported that they believed the mental disorders/illnesses might have been brought about by sorcery and/or witchcraft, and they first consulted a traditional healer, whom they will continue to concurrently consult together with Western medicine

1.5 OBJECTIVES OF THE STUDY

The study aims to explore the beliefs and practices or consultation patterns of the African communities in mental illness. This study will suggest implications for health policy planning as well as the enhancement of co-operation between divergent health systems.

The study will further explore, whether there are any differences in the black community's causation beliefs and the relationships of these beliefs with treatment choices, attitudes towards both Traditional and Western healing systems, according to sociodemographic characteristics (that is, geographic location, gender and age differences).

CHAPTER TWO

2. THEORETICAL BACKGROUND AND LITERATURE REVIEW

2.1 AFRICAN TRADITIONAL WORLD-VIEW

The African world-view has been (always) as a credible paradigm from which to understand psychopathology. It is thus necessary to set it in its proper context in terms of existing paradigm, for example, Jung's archetypes. In the following text, the Black traditional world-view will be put into a comprehensible outline and its link with the existing theory.

The African world-view or African cosmology, represents the basic philosophy of life of African people. It is an abstraction which encompasses the total way of life of the African society. It is a psychological reality referring to shared constructs, shared patterns of belief, feeling and knowledge (of the basic values, axioms and assumptions) that members of the group carry in their minds as a guide for conduct and the definition of reality (Mabetoa, 1994). Reality in this world-view, according to Mabetoa, is not only that which is definable in

rational terms or acceptable because of proven conclusions; It includes such experiences as dreams, visions, spirit possessions, precognition and life after death. The experience of health or illness is influenced by world-view, and each world-view presents its own method of healing.

An understanding of Black ontology is a prerequisite to clearer understanding of black concepts concerning health and disease. Viewed against this background, Makwe (1985) maintains that, Blacks have their own distinctive concepts concerning disease and health, concomitant and desirable behavioural patterns, curative powers and also persons capable of healing. The role of the African world-view however, has been severely undermined by agents of change that date back to the colonial era. Adequate knowledge of the African world-view is thus necessary for those clinicians who have to deal with the ever-increasing number of African people needing psychological services.

Sekyere (1983) maintains that, there are three categories of being that cannot be reconciled with western concepts, namely, ancestors, various nature spirits and the powers of the witches and sorcerers. Mabetoa

(1994) also maintains that, one characteristic of African cosmology is the non-separation of all things-living and non-living, the pre-born, the born and the dead. Symbols, myths, values and rituals play a vital role.

Reverence for ancestors is an important aspect of the African world-view, and ancestral spirits are seen as being primarily instrumental in the protection of the individual from any misfortune. Such protection is lost if ancestral spirits are offended and illness, particularly psychiatric disorders may follow as punishment (Makwe, 1985). This African way of life has decided implications for health and more specifically for mental health; This is because it determines the individual African's explanation of mental illness (that is, causation) as well as their overall perception and definition of mental illness, which determine the individual's psychiatric help seeking behaviour.

The African world-view therefore, as Bodibe (1992) stated, has a tremendous influence on the conceptualisation of mental health and illness. Thus whether a syndrome is diagnosed as Thwasa (a calling of the ancestors) or schizophrenia may well depend on the world-view that

the healer and consumer of the health service are using. He further emphasised that, the notion of mental ill health is fundamentally different in Western understanding of psychopathology as shown in the DSM-IV.

Traditional healing permeates all aspects of African life, therefore South African's indigenous healers can only be truly understood in the context of their culture and world-view. Airhinhenbuwa (1995) maintains that, when people define physical or emotional symptoms within a traditional taxonomy, they are likely to seek help in the traditional health care system.

2.2 JUNG'S ANALYTICAL THEORY

There is an inextricable relationship which exists between indigenous healing and the emotional and spiritual dimension of being (Hold stock, 1979). Traditional medicine often has a pronounced symbolic connotation and as Bodibe (1992) cites, it also involves the unconscious aspects of the mind. The main interpreter of these symbols is the indigenous healer.

Jung's theories have several synchronicities with indigenous healing. According to Strake (1994), it is essentially Jung's work with dreams, his process of individuation, and his concepts of the collective unconscious and archetypes which share a great deal of commonality with the principles underlying culture and indigenous healing. Jung's work implies that there is a cultural level of unconsciousness. The archetypes in the collective unconsciousness are shared by all people, but the symbols by which these archetypes are expressed are unique to their culture (Steyn & Motshabi, 1996). They maintain that, Jung suggested that people have a collective unconscious containing patterns or archetypes of life and behaviour derived from ancestral inheritance.

The beliefs are symbolic representations of the collective psyche which express enduring concepts and values applicable to all people (Henn, 1990). It is suggested that the images of the ancestors, witches and sorcerers are expressed in the African cosmology, are projections from their unconscious, especially the cultural and collective layers (they are archetypes) (Wajsman, 1986). It must be stressed that indigenous beliefs about the spirit world, dreams and health, permeate all aspects of the work of indigenous healers.

Every culture has systems of symbolic meaning that may be overtly expressed and experienced through belief systems, such as those about mental illness. Hence the experience of mental illness could be described as a cultural or symbolic reality (Makwe, 1985). Wajsman (1986) maintains that, African people are still to a large extent in touch with their archaic layers of their psyche and the symbols from these, still have power and meaning for them. African world-view together with its traditional healing system can be seen through the theories of Jung.

2.3 BELIEF SYSTEM AND CULTURAL INFLUENCE

All people view the world based upon their particular belief system. For blacks in South Africa, their cultural and social beliefs have been shown to contribute to the way they conceptualise illness, disease and use of health care facilities (Pillay, 1996). Airhihenbuwa (1995) also explains that, the sources of prevention and cure of particular problems are determined to a great extent by the client's sociocultural and religious backgrounds. The beliefs, values, attitudes, feelings and behaviour of ethnic group members have a direct impact on their psychological functioning, their concept of illness and their expression of symptoms (Aponte, Rivers and Wohl, 1995).

The African through his belief system, seeks answers to the question of why something occurs, not only how it occurs. These factors also affect their entry into the mental health system, the types of services provided, the processes involved in working with them and the outcome of the interventions or treatment given.

Indigenous beliefs about medicine in South Africa span the natural, supernatural and spiritual realms (Freeman & Motsei, 1992). As a result, the African belief system plays an important role in solving and explaining the mysteries of illness and misfortunes. Cheetnam and Griffiths (1982) also emphasises that, for most traditionally oriented African people, health care revolves around the magico-religious belief system; medicine is not only to cure disease, but also to ensure good luck, fertility, success and promotion, to ward off bad-luck and to protect against evil, witchcraft and sorcery.

Culture is a system of interrelated values active enough to influence and condition perception, judgement, communication and behaviour in a given society (Mazzrui, 1986, as cited by Airhihenbuwa, 1995). Vontress

(1991) is of the view that, to a large extent culture and health coincide. The culture in which people are socialised determines the beliefs that they hold about the nature of their problems, and the way they may be solved. He further noted that, cultural influences affect not only perspective on health, illness and disease, but also a variety of health-related behaviours, such as beliefs that underlie the utilisation of services and seeking of medical care. It also influences the specific manner in which people behave when they are ill, the communication of the problem and how symptoms are presented (Wajsman, 1986).

As Mabetoa (1994) has stated, Africans have a very different concept of illness and bodily suffering from the approach suggested by Western culture. They for instance attribute other illnesses as caused by ancestral spirits or man-made through sorcery and witchcraft. Thus psychological theories developed in one culture may not readily be generalizable to the behaviour of the people of another culture. Buhrmann (1977) as cited by Mabetoa (1994), states that, the so called hallucinations and delusions (in the African sense), do not have the significance that the Westerner ascribes to them. Many of these perceptions appear to be normal in the context of their culture because these are shared experiences.

There is increased pressure for the providers of mental health services to acknowledge the importance of their consumer's cultural environment. This is due to the fact that the Western conceptual model of illness is rarely fully consonant with the beliefs, expectations and world-view of Africans (Makwe, 1985). Marsella and White (1984) suggest that, culture is not simply incidental to mental disorder or therapy; rather it is a basic variable which interacts with biological, psychological and environmental variables in determining the causes, manifestations and treatment of the entire spectrum of mental disorders.

The African therapist lives within the belief system of his culture. S/He diagnoses and treats mental disorder within the constraints imposed by this supernatural system. S/He has tended to be effective in treating psychiatric disturbances because these are believed to be caused by supernatural factors; and are thus not considered to be within the competence of modern medicine to treat. The indigenous healer through the process of divination explains the why and how events occur, which tallies with the expectations of the African population.

2.4 CONCEPTUALISATION OF MENTAL ILLNESS

The cognitive determinants model of the perception of mental health status suggests that people's perceptions of their health and mental health status may be largely determined by their concept or definitions of health and mental health (Hourani & Khlat, 1986). According to Bodibe (1992), the African world-view has a tremendous influence on the conceptualisation of mental health and illness. In turn the individual's perception and definition of mental illness, seems to play a major role on his pattern of psychiatric help seeking. This perception has historically been determined by the African world-view amongst Africans.

Sekyere (1983) maintains that, indigenous African views on illness and health in general and mental illness and health in particular are holistic and cosmological in emphasis. Srinivasa and Trivedi (1982) maintains that, African perception of mental illness is based on relation with the natural, supernatural and social environment. However this perception is determined by the individual's commitment or degree of adherence to the traditional belief system.

Le Roux (1973) as cited by Makwe (1985), found that a fine discrimination between the various forms of psychoses does not exist within the semantic framework of the African. Srinivasa and Trivedi (1982) also agreed that, no one could mention the names in vernacular about the types of mental illness although awareness about different degrees of the severity of the illness was present. It has been suggested that mental illness is equated with psychosis in most African cultures, and all types of mental illness are referred to by common term "botseno" (madness), by the lay people. Only those patterns of behaviour which constitute a threat to social cohesion and balance, that is, disturbed behaviour and/or extreme disturbances of expression and reason are regarded as "madness" amongst rural Africans.

2.4.1 CAUSATION THEORY

The African world-view and the belief system of its population offers a different view of the causation of mental illness, from that of Western culture. There is a widespread belief that the cause of illness and misfortune has a locus external to the individual and is mostly spiritual or spiritual combined with physical.

According to Mabetoa (1994), the most important causative agents of mental illness amongst Africans according to the traditional view of such illness, seem to be the ancestors, discord in the interpersonal relationships, magic and witchcraft and pollution and the breaking of taboos. Disease or misfortune is ascribed to the active, purposeful intervention of an agent which can be human (a witch or sorcerer), non - human (a spirit or ancestor) or supernatural (a deity or other very powerful being) (Van Rensburg, et al. 1994).

The distinction is made between theories of natural and supernatural causation (Edwards, 1986)

(I) THEORIES OF NATURAL CAUSATION

(a) Biological Factors

This can be seen as any theory, scientific or popular which accounts for the impairment of health as a physiological consequence. This category, according to Murdock, et al. (1980) as cited by Edwards (1985), is recognised by modern medical science with its empirical traditions, for example, as in the case of infection, stress, organic deterioration and accidents.

In addition heredity may be held to be implicated in illness (as in cases of epilepsy). Ecological or environmental factors may form the basis for and explanation of illness, for example, substances which are dangerous to health are believed to be deliberately placed in a pathway by an enemy.

Conco (1991) asserted that, biological (natural) factors relate to beliefs regarding malfunctioning of the organism. In the interview which I had with Ngaka Jongane and Moseje, it was raised that mental illness (Botlhoko ba tlhaloganyo/botseno) can be caused by illness of the womb in women. They also explained the causative agent as being brought by meeting with a partner sexually, who has "bad blood" or has used "sethlare" medicine that can not go on well with the other partner.

(ii) THEORIES OF SUPERNATURAL CAUSATION

In these theories, illness is ascribed in terms of external forces.

(a) Social factors

Non-observance of restrictions placed upon the individual by the society or culture, that is, taboos, is often regarded as a precipitation of illness.

According to Ngaka Ndimande, non-observance of certain rituals like "bogwera" and "bojale" (circumcision) in families that subscribe to this ritual may lead to mental illness. "Sejeso" or the ingestion of noxious substances prepared by sorcerers and introduced into the victim's food by someone bearing a grudge or grievance against that person, is another causative phenomenon.

(b) Religious factors

Religious beliefs in the African societies centre on the pervading influence of the ancestors who form a vital link between god and the people. Mental illness may follow as the ultimate sanction for refusal or failure to obey specific instructions (from ancestors) such as training to become an indigenous healer (Makwe, 1985). Invocation of the displeasure of the ancestors is frequently given as an explanation of illness, for the ancestors are seen as being primarily instrumental in the protection of the individual, the family and the community from any misfortune.

© Magical factors

Principally these relate to sorcery and witchcraft which incorporates the activities of the different types of witches and familiars they use. It is believed that an individual who is sufficiently envious and resentful of the achievements of another may cause harm:- accidents, illness even death through appeal to intermediaries of the spirit world (Fernando, 1991). He further asserts that, looked at from the opposite perspective, people suffering from the mental illness would regard themselves as the innocent victims of cruel fate or the machinations of envious malevolent members of their communities.

2.4.2 CONSULTATION PATTERNS

One of the major areas of clinical relevance of folk theories of mental disorder is their influence upon health care decisions and the selection among alternative forms of treatment (Marsella & White, 1984). People's health beliefs strongly influence their health and illness behaviour (Pillay, 1996). The decision to seek help (beyond what the family has to offer), involves in the African context a choice from one of the three possible modes of action. These include exclusively Western agents only, an

exclusively traditional/indigenous agents only or a dualistic mode (both indigenous and Western agents). A significant proportion of the African population adhere to traditional beliefs regarding health, illness and care (Snyman, 1992).

As long as people perceive misfortune and sickness to be related to the spirits, the need for healers with a similar world-view will continue to exist. Freeman and Motsei (1992) asserts that, in many cultures indigenous healers, who work in the context of indigenous beliefs are consulted in preference to western doctors. When people define physical or emotional symptoms within a traditional taxonomy, they are likely to seek help in the traditional health care systems (Airhihenbuwa, 1995).

However, Sodi (1987) alluded to the fact that, it would seem the Western influence which Africans get in education, urbanisation and contact with European thought, should influence their decisions of value system and health care systems. Whilst this may be true, other studies have shown that traditional healers are regularly consulted by most urban and rural

Africans. In his study, Sodi found that, 67.4% of respondents admitted to have consulted a traditional healer. This figure shows that most people continue to use the services of traditional healers despite the fact that alternative health care facilities exist. He further noted that, it is not uncommon for Africans to go to a Western agent for treatment proper, whilst at the same time consulting the indigenous healer so as to "understand" the particularity of the disorder or to answer the question "Why?".

According to Conco (1991), who practices as a Psychiatrist, states that "*Before we see a patient in our Western medical offices, they have passed through the hands of the traditional practitioner or "Ngaka", or in some cases of mental, they have seen the "sangoma""*. Even amongst people who generally use Western medicine when they are sick, there are particular instances when the illness is seen to have African experiential causes and can therefore not be treated by allopathic medicine (Freeman & Motsei, 1992).

The type of mental illness, what the individual thinks is its cause and how he/she perceives it, determines the type of competence (Western or Traditional) that will be thought of as appropriate for that illness. According to Sekyere (1983), there is evidence from throughout Africa that mental illness is one of the conditions for which modern medical help is least likely to be sought.

2.4.2.1 GENDER INFLUENCE

Sex has been found to determine help-seeking. National data support the perception that men and women differ in the overall rate of visits to health care services (Muller, 1992). Women's traditional role in some cultures as the primary care of children, has a significant influence on the manner in which distress is manifested and must therefore be taken account of in any treatment package offered (Bhui, Christie & Bhugra, 1995).

According to Muller (1992), comparison of the relations of the two sexes with the health care system in statistical terms shows that, generally, women have a more active connection with health care providers. Hence women have generally been thought to be more likely to seek care early

in response to symptoms. Rothblum and Cole (1990) are of the view that, women are exposed and oriented to the use of alternative facilities such as spiritual churches and indigenous traditional healers. However Snyman (1992), in his study of the utilisation of traditional healers, found that, men and women consult traditional healers to the same extent.

2.4.2.2 AGE INFLUENCE

Age is another factor that influences people's help seeking behaviour. Previous studies suggested that older people, in the African context, often went to see "dingaka" due to their strong traditional belief systems as compared to the younger generations (Jehoda, 1979, cited by Wajsman, 1886). Fenyves (1994) asserts that, the new generation believes in the Western things because education does not talk about traditional things and traditional medicine. Snyman (1992), in his study, also demonstrated that, traditional healers are consulted more frequently by people in the higher age category than those in the younger age category.

2.4.2.3 WESTERNIZATION INFLUENCE

In South Africa with the various cultural differences among its people, Western culture appears to take precedence over non-western cultures (Ramokgopa, 1993). Urbanisation amongst Africans has been shown to effect a shift towards Western agents in their preferences or choice of mental health care providers. Ramokgopa further maintains that, generally people who openly admit to consulting traditional healers are viewed as uncivilised; It is expected that civilised people would naturally renounce any "primitive" supernatural or magical beliefs, since these cannot be scientifically explained; People who have such beliefs are viewed as being superstitious. To avoid being labelled as such, people do not readily and openly associate themselves with the practices of the traditional healer.

However, since the collapse of colonialism, the African sociocultural identity has slowly been revived and with it traditional medicine as part of that cultural heritage. Conco (1991) has suggested that, the acculturation process presents the African with several choices; The individual might choose to retain his traditional view and entirely ignore the scientific view,

or choose to utilise both these views as influenced by the type of illness experienced. The suggestion here is that, urbanisation exposes the individual to alternatives which he can still choose to reject.

2.5 AFRICAN TRADITIONAL HEALING

Traditional medicine is a term used to describe culture-bound health care practices, that has survived in South Africa and has up to the present continued to exist as a well established health care system in both rural and urban areas. It is an ever present reality and is an approach to mental health which should not be neglected in South Africa.

Traditional healing is perhaps the only health system that is accessible to everyone in Africa. Hopa (1997) demonstrated that, about 80% of the South African population make use of traditional healing methods. However Conco (1991) asserts that "Traditional medicine has its many shortcomings, just as we have in ours (Western oriented healing) or any other medical system for that matter".

Generally, traditional African medicine is the totality of all knowledge and practices, whether explicable or not, used in diagnosing, preventing or eliminating a physical, mental or social disequilibrium and which rely exclusively on past experience and observation, verbally or in writing (Fenyves, 1994). Tsey (1997) maintains that, for indigenous people in South Africa, resurgence of interest in traditional medicine is part of the anti-colonial struggle and pride in cultural identity. Traditional medicine is also being actively promoted by the World Health Organisation and other international agencies throughout the third world.

Traditional healing involves the whole person, care is not only directed at the biological aspect of the person, but at the social, psychological and spiritual as well. In all forms of traditional healing, religion and shared cultural values and beliefs are at the core of preventive and curative health practices. Religion, magic and superstition, and their resulting practices (e.g. traditional medicine) are all based on rationality. Such rationality is best understood in its traditional context rather than through a Western paradigm, hence the popular utilisation of traditional medicine (Airhihenbuwa, 1995). According to Aponte, Rivers and Wohl (1995),

individual cultural differences are reflected in indigenous traditional healing practices; however extensive borrowing and some cross-utilisation also takes place.

Traditional healing in general, has a humanitarian element, tracing the cause and origin of the disease (often social in nature) and by so doing, helping the patient with the ridding off of social disharmony (Fenyves, 1994). In indigenous healing practices, the traditional healer is consulted not only in times of illness but also when an evil omen is noticed or when actual misfortune such as an accident and quarrels in the family occur.

2.5.1 TRADITIONAL HEALERS

Traditional healers have been the main providers of health care in Africa for centuries but until now, they have not been given their deserved place in the formal health care in South Africa. In African countries like in Swaziland, Zambia and Zimbabwe to mention but a few, the traditional healers has the same status as the Western medical practictioner. They continue to represent a major therapeutic resource despite a changing sociacultural context (Makwe, 1985).

The term traditional healer collectively refers to people who use traditional African methods of healing, based on African beliefs, culture and customs. Such methods include the use of medicine, magic, religion and spirits. The role of the traditional healer is quite crucial since he/she has an understanding of his/her community, its value systems and interpersonal patterns. Lambo (1963) as cited by Ramokgopa (1993) noted that, shared world-view contributes greatly to the success of the treatment of emotionally disturbed people. Traditional healer's proven powers of divination and expertise in the treatment of particularly psychological disturbances, as well as their comprehensive understanding and awareness of ecological, sociological and economic variables operating in the community, account for their dominant instrumental influential social role within the community (Makwe, 1985).

Traditional healers do not have a standardised training as in Western medicine, and they have to follow a call which is not a voluntary process. After being selected by ancestors, through illness (thwasa) or dreams, undergoes some training with a qualified traditional healer. The power of healing spirit enters him/her and she/he also starts practising as a healer

(Bodibe, 1992). They are known by different names, depending on the country, ethnic group and language used to describe them. Terms such as:- Indigenous healer, Traditional healer, Diviner are used interchangeably in the literature when referring to these individuals. Strake (1994) maintains that, the indigenous healer is not only Psychologist, Physician and Priest, but he/she is also the tribal historian. He/she acts as an intermediary between the known and the unknown, between the living and the "living-dead" (Mabetoa, 1994).

The indigenous psychotherapist, according to Makwe (1985), is secular-scientific in his approach, observing nature on the one side (natural) and magical beliefs (supernatural) on the other. He/she not only serves as a healer of physical illnesses, but also performs other important functions within the community. These functions include his role as a spiritual mentor, as a dream analyst, as a community Psychologist and as a Psychotherapist (Ramokgopa, 1993). Buhrman (1992) asserts that, traditional healers plays a key role not only in the health of the individual and his family, but also in the social cohesion of the group.

Traditional Africans believe that healers can cure a variety of problems:- infertility, mental disorders, bad dreams, impotence and fractures (Vontress, 1991). According to Fenyves (1994), a traditional practitioner's duties are:- to cure diseases, play a preventive role, counsel patients, guide and advise them, reconcile families, make people's lives run smoothly by solving their money problems, love problems, work problems, sexual inefficiencies, addressing mental disturbances and the list is inexhaustible.

It is clear that traditional healers play a very important role in the care of indigenous communities. In a report submitted to the WHO, it was argued that, traditional healing forms the essential core of primary health workers, for nine-tenths of the population of the third world (Wajsman, 1986). Corporate South Africa is also beginning to take traditional healers seriously. Now, like it or not, traditional healers and their role in South African society are going to be the front-burner of the national agenda.

Bodibe (1992), Gumede (1974) and Freeman and Motsei (1992) give us different types of traditional healers; much as there is a stratification of traditional healers, there are no water-tight compartmentalised groups.

(I) Sangoma (Diviner)

In many cultures the Diviner-healer is at one and the same time a religious leader. He/she operates within a religious, "supernatural" context and in touch with the ancestors and the spirit world. They are healers who can see into the remote past and the distant future and also make use of "magic". Sangoma dance may be used to diagnose and find cure. Once they are in a trance, they are able to communicate with the ancestors and are able to tell the patient what is wrong (Bodibe, 1992).

(ii) Raditlama - tlama (Herbalist)

He/she is usually well versed in the pharmaceutical and pharmacognostic aspects of herbs, plants, roots and leaves. He/she mixes these in a manner which will make them effect the desired cure. He/she is considered to be the traditional pharmacist.

(iii) Moprofita (Faith healer)

He/she integrates Christian ritual and traditional practices (Freeman & Motsei, 1992)

(iv) Ngaka (General practitioner)

Ngaka can be equalled to a Western trained general practitioner. He/she practices as a physician and also as a "priest", soothsayer, diviner etc. These physician-seers, Bodibe maintains that, they are the masters of the healing art, combining their wide empirical knowledge of medicines with their astute insight into traditional culture.

2.5.2 DIAGNOSIS

The process of diagnosis in traditional healing is quite different from the method of either bio-medicine or psychotherapy. The traditional healer, like his people, usually attribute the origins of psychological or behavioural maladjustment to non-human factors, which is very different in regard to Western-oriented health professionals. Vontress (1991) maintains that, the belief in animism acts as a powerful force on the traditional African's understanding of difficulties in life. The notions that every object and being has a spirit and that the "dead" pass into as invisible dimension influence not only the healer's diagnosis of problems brought to him but also the patient's willingness to accept the analyses of them.

Traditional healers use a variety of procedures to diagnose client's problems. Diagnosis can be done either through head divination or bone throwing. Some take a rather long "medical" (psychological, physical and spiritual) history as do their Western counterparts; others are said to be able to diagnose from a distance without ever seeing the patient; still others arrange an elaborate ceremony designed to invoke the spirits of ancestors to obtain needed answers; others use mirrors to "see" the problems (Vontress, 1991).

2.5.3 TREATMENT APPROACHES

Treatment by traditional healers generally is believed to be effective and the treatment of choice for unnatural forms of illness (Fernando, 1991). The shared beliefs between the healer and the community, help to facilitate treatment and to reduce possible doubts. The African traditional healing emphasises the unity of body and mind, and tends to be more holistic in its approach to diagnosis and treatment. Buhrmann (1992) emphasises that, consistent with the Black man's holistic concept of man and of illness, their indigenous healing practices are directed at the whole person and embraces all aspects of life. This occurs mainly through the

activation and use of symbols which draw together and unite experience. The main interpreter of these symbols is the indigenous healer.

Traditional healers use a number of techniques singly or interactively to eliminate, ameliorate or prevent physical, psychological and spiritual problems of their patients. In the syndrome known as "Thwasa", the traditional African treatment would be for the sufferer to undergo training to become a Sangoma. In Western context the same sufferer would probably be hospitalised and given psychiatric treatment in the form of medication and possibly psychotherapy.

The traditional diviner is directive in his approach. He gives advice to his client by functioning as the mouth-piece of the ancestors who posses superior wisdom. Hence Bodibe (1992) puts it that, guidance is therefore from the unconscious and not from the ego of the healer. In most cases they do not treat a patient or sufferer as an isolated individual. Instead they treat their clients as integral components of family units or as part of the community at large (Degouveia, 1992).

The procedures which the healers adopt consist of, among others, possession dances, pharmacotherapy, Exorcism, music, application of holy oil or water, counselling and dream interpretation. There are other special techniques which are used by the different types of healers in bringing about cure in their patients. Among others these techniques include, manipulation of the environment, "vaccination", rituals and sacrifices (Sodi, 1987). The making of sacrifices and rituals is a psychological device to restore the ontological balance. In African traditional healing, the ritual is believed to mobilise natural or supernatural healing forces on the patient's behalf. Conco (1991) also stated that, the rituals and sacrifices also have their psychotherapeutic value.

2.5.4 ESSENTIAL PREREQUISITES OF HEALTH SERCVICE (EQUITY)

Traditional healing has been sustained over the years partly because it is based in cultural values and norms of the people and partly because it is available, acceptable and affordable. Equity in psychological services is central to a just society and fundamental to the development of mental health care for all. Equity refers not only to non-discriminatory admission to facilities, but to the affordability of care, the geographical locality of services and the cultural appropriateness of interventions (Freeman,

1991). In this text traditional healing will be looked at in terms of Coe's scheme of prerequisites for health care system.

(I) Accessibility

It has often been stated that traditional healers are accessible because, compared with Western medical practitioners, they have the advantage of cultural, social, psychological and physical propinquity (Snyman, 1992). Considering the healer-population ratio, Snyman maintains that, physical propinquity is indeed a reality, although distance does not seem to act as a deterrent when seeking the services of a traditional healer. As a matter of fact, a person often prefers to consult a healer in another area, on the one hand because the client expect the traditional healer to identify the problem without prior information, and on the other, because the person (neighbour) who wishes to harm him, might consult the same healer should he live nearby.

At present in remote areas and in urban "townships", for many people, primary health care may be synonymous with traditional medicine. For the foreseeable future at least it would seem that traditional healers will continue to offer greater accessibility.

(ii) Availability

Owing to a lack of official statistics, the man power situation in the traditional sector can only be estimated. According to Van Rensburg et al. (1994), the traditional healer : population is estimated at 1:200. Campbell (1998) has however suggested that, there are about 200 000 traditional healers in South Africa. This suggests a massive consumer base. In contrast, the concentration of Psychologists and Psychiatrists in the urban areas; the inability of people in the rural areas to pay for services and the fact that posts for Psychologists hardly exists in these areas. According to Pillay and Petersen (1996), this suggests that, the white urban population has relatively greater access to services of clinical and counselling Psychologists than black and rural communities.

(iii) Acceptability

The approach of the traditional healer incorporates the world-view of the culture within which he works, and his ministrations are consonant the prevailing beliefs of the community. The traditional healer and the patient share common values and an cognitive understanding of the situation. This makes the services of traditional healers to be acceptable to the indigenous population. Uys (1992) shares the same sentiments by

maintaining that, today traditional medicine is still a refuge for large portions of the Black population, not only because there is no other choice or possibility, but also because this population deems it acceptable and functional. This also enhances the traditional healer's personal qualities and enables him to function effectively.

(iv) Accountability

The prerequisite of accountability specifies that "providers are for assuring the quality of services rendered, both technically and organisationally, to monitor continually the scientific competence and the continuity of services provided" (Coe, 1978, cited in Snyman, 1992). It is obvious that this prerequisite can only be realised when the traditional medical system obtains a different legal position from the one laid down in 1974.

2.6 WESTERN MEDICINE

Western medicine is practised along side other alternative health care systems, and it was all along being regarded as the only popular system of health care in South Africa. Western medicine is based largely on scientific and logical principles, which have no direct link with any

religious beliefs and symbolism (Bodibe, 1992; Steyn & Motshabi, 1996). Fenyves (1994) and Edwards (1986) explains it to be a cultural system and a product of European history, that is based on the empirical specialised biomedical model of natural science.

In Western medicine and psychiatry, diagnosis is based upon a history of sickness given to the Doctor by the patient. The Doctor then deduces the nature of the disease following established methods generally accepted throughout the modern system (DSM-IV) (Sodi, 1987). The aetiologic (explanatory) models tend to identify the causes of mental disorder largely within the individual's psyche. The psychological sphere is given preference (that is, the person's feelings, thoughts and behaviour), rather than being holistic. Hence Vontress (1991) raised a point of concern that, Western counsellors who focus exclusively on the psychological component of human existence are apt to misdiagnose the problems of their African clients.

In the case of Western counselling, the intervention relies strongly on scientific validity. Counselling is based on the principle that the client has to take responsibility for his own actions and decisions and is therefore

non- directive. Its agents of mental health include:- Psychiatrists, Psychologists, Psychiatric social workers, Occupational therapists and Psychiatric nurses; of whom, many have rejected traditional healing outright, because it is said to be "primitive" and "pseudo scientific" (Freeman & Motsei, 1990).

In this text, the influence of the African world-view, which has an impact in the belief system of the Black population, particularly in their health and illness perceptions as well as in their choice or preference of different treatment systems. Led the researcher to the following hypotheses.

2.7 HYPOTHESES OF THE STUDY

If the healer and patient belong to the same cultural group, there is no cultural gap which needs to be bridged, no cultural discordance and no language barrier. The explanation of illness and its aetiology is the same. It is then hypothesised that, the majority of the Black community will have more positive attitudes towards traditional healing.

2.7.1 There will be a high incidence of consultation among Black communities of traditional healers in cases of mental pathology.

2.7.2 It is hypothesised that, there will be a difference in the attitudes and practices of respondents, according to age difference, towards mental illness and traditional healing.

2.7.3 There will be a significant difference in attitudes and consultation patterns across the gender characteristic of the communities.

2.8 DEFINITION OF CONCEPTS

(I) BELIEFS

Beliefs are symbolic representations of the collective psyche which expresses enduring concepts and values applicable to all people (Macmillan Dictionary of Psychology, 1989). They are also said to be an individual's more or less organised set of attitudes, opinions and convictions that implicitly or explicitly affect his behaviour, interpersonal relationships and attitudes toward life. In terms of the study, beliefs include the perceptions the individuals has in terms of mental illness and

the different treatment options, for example, their attitudes and opinions about mental illness and traditional and Western healing modes.

(ii) PRACTICES

This pertains to the methods of action or working; The habitual way or mode of acting, doing or carrying on of something, usual, customary or constant action (New Webster's Dictionary, 1991). Focus in this study is on the consultation patterns; the utilisation or choice of different mental health services, from the consumer's point of view.

(iii) MENTAL ILLNESS

Mental illness is defined in the Mental Health Act, 1973 (Mental Health Act, Act 18 of 1973) as follows:- "Any disorder or disability of the mind, and includes any mental disease, any arrested or incomplete development of the mind and any psychopathic disorder (Section 1(XI)). According to Le Roux (1973), cited by Makwe (1985) explain mental illness or pathological behaviour as a condition in which the individual suffers personal distress, has disabling behavioural tendencies and on account of poor contact with reality, is unable to deal appropriately with the demands of his environment.

(iv) AFRICAN PEOPLE

The term African generally refers to the indigenous inhabitants of Africa, that is, people who were living on the African continent prior to its colonisation by Western powers. In this study, the term African people refers only to Black African inhabitants with special reference to those in the Southern part of Africa excluding Asians and coloureds, particularly within the Tswana speaking communities.

(v) TRADITION

Any social custom or belief or a co-ordinated set of such customs and beliefs that are handed down through the generations (Dictionary of behavioural sciences, 1973).

In this chapter the views of the Black indigenous communities influenced by different factors were discussed. The African cosmology was revealed and its impact on health and illness of the population. Different factors like Westernization, gender and age were also looked into, in influencing peoples beliefs and practices. Traditional healing was also elucidated, so as to give more information in its dealings and practices.

CHAPTER THREE

3. METHODOLOGY

3.1 RESEARCH DESIGN

A survey method will be used to gather information with regard to the purpose of the study, namely: to investigate the beliefs and practices of the community in mental illness and their choice of treatment. This is in line with the views of Graig and Metze (1979) cited by Ramokgopa (1993), who regard a survey as an empirical and logical study involving the systematic and impartial collection of data from a sample of cases as well as the statistical analysis of the findings.

The survey method has the following advantages:-

- It is original, that is, data to be obtained does not exist in one form or another.
- It is self-reporting in the sense that the content are essentially the respondent's own opinion of the particular matter under investigation.
- It is standardised in that data are obtained by uniform procedures.

One of the limitation of the survey method is that the cost of personal interviews are exorbitant. To offset the cost, the researcher will limit the number of the subjects. Another disadvantage of this method is the time limit. Due to time and cost factors, the survey data are often regarded as artificial in the sense that they do not penetrate deeply into the participant's knowledge on a particular problem or topic.

3.2 PARTICIPANTS

Two groups of respondents were used in this study, (that is, 16 from the urban and 16 from the rural areas) participants drawn from Mafikeng residential areas and surrounding villages. Participants were drawn from the black population, within the age groups of 18-40 years and 40 years upwards.

3.3 SAMPLING PROCEDURE

A multistage cluster sampling technique was used to draw 32 participants from the target population groups. This technique has ensured random inclusion of respondents in each population group.

(I) First stage

Random selection of two residential areas in Mafikeng (urban area) - Unit 8 and Unit 12; and two surrounding villages (rural area) - Ramatlabama and Setlopo.

(ii) Second stage

Random selection of dwelling units (households) in both urban and rural areas (16 from the urban area and 16 from the rural area).

(iii) Third stage

Random selection of a single respondent per unit, on the basis of age and sex.

The table below summarises the sampling procedure.

TABLE 1: Table of the sampled participants

		Males		Females	
	Age	18-40 years	40 years and above	18-40 years	40 years and above
Urban Area	Ramatlabama	2	2	2	2
	Setlopo	2	2	2	2
	Total	4	4	4	4
Rural Area	Unit 8	2	2	2	2
	Unit 12	2	2	2	2
	Total	4	4	4	4

N = 32

3.4 Description of the sample

The sample consisted of 32 respondents (N = 32), with 50% of the respondents drawn from the rural population and the other 50% from the urban population. The majority of respondents were from the Tswana ethnic population (90.63%), and the other percentage of the sample was composed of respondents from other black ethnic groupings.

A large number of the respondents had acquired secondary education; 65,62% had secondary education, 18.75% had or were pursuing tertiary education, and 15.63% had primary education. The occupations held by respondents varied from professional, non-professional, students, pensioners to unemployed. The majority of the respondents were falling within the non-professional category (40.62%) with 28.13% falling within the professional category, 6.25% were students, 6.25% were pensioners and the remaining 18.75% were unemployed.

The religious denomination of the respondents varied very much, with other churches having an influence in the health beliefs and practices of their congregations, like the Holy Heaven and the Native church, with one prohibiting the use of traditional medicine and the other encouraging the use of traditional medicine respectively.

3.5 RESEARCH INSTRUMENT

Direct and semi-structured interviews were used, using an audio tape recorder and also noting some responses verbatim from respondents. The questions and interviews were carried out in Setswana, which is the ethnic language used by target population, and were again translated into English (see Appendix A and B). Translating and back-translating of the interview questionnaire was made to ensure instrument validity.

In addition to biographical details, the following main dimensions were addressed in the interview schedule:-

- Conceptions regarding disease aetiology (mental illness)
- The utilisation (consultation) of the services of the different types of medical facilities and practitioners.
- Choice of facility and/or practitioner in terms of mental illness.
- Attitudes towards connecting traditional and Western medicine.

The advantage is that the technique was capturing real-life life data in social environment and possessed flexibility. The slope of explaining to the respondents was increased.

3.6 PROCEDURE

The researcher himself was responsible in conducting individual interviews with the respondents. The preamble and aims and objectives of the study were explained to respondents and an agreement reached for participation. In cases of rural population, a permission was initially sought from the relevant "KGOSIS" (tribal authorities) of different villages. Interviews were recorded using and audiotape recorder while other responses were noted verbatim by the interviewer.

3.7 DATA ANALYSIS

The responses were content analysed into themes and percentages were calculated. Responses were translated into English prior to contextual analysis. X^2-tests were computed for categorical data to analyse any differences, in relation to sex and age characteristics of respondents.

CHAPTER FOUR

4. RESULTS

The majority of respondents cited both natural and supernatural factors as the aetiology of mental and/or psychological illness (96.88%), and only 3.12% cited natural factors exclusively as the cause of mental illness. Many cited environmental factors like poverty and suffering and mostly sorcery and witchcraft in cases of supernatural causes.

15.63% of the respondents think that mental illness can be successfully treated exclusively through traditional healing and 18.75% think that mental illness can successfully be treated exclusively through Western healing system. 65.62% of the respondents favour a dual consultation for better and efficient treatment of these illness.

All the respondents (100%) identified abnormal behaviour and speech as the main signs of mental illness.

The majority of the respondents, 87,5% admitted to have consulted traditional healers before; with only 12.5% reporting to have never

consulted traditional healers before. This confirms the hypothesis that, the majority of people within the Black population have a positive attitude towards traditional healing system.

The majority of the respondents, 68.75% cited family norms and themselves as influencing their decision to have consulted traditional healing system previously; while 31.25% of the respondents reported to have been advised or referred by relatives and/or friends.

About 56.25% of the respondents, reported to have started consulting in Western healing system in the past. 31.25% have reported to have started consulting traditional medicine first. Most of the reasons put forward were that, they were not successfully treated in Western healing system, hence they resorted to traditional healing after consulting in the Western system. On the other hand, those who started consulting in the traditional system then later resorted to Western healing, cited complementing traditional medicine with Western healing for better diagnosis and treatment.

The majority of the respondents, 68.76% reported to have equally positive attitude towards both Western and traditional medicine acting jointly, while 15.62% of the respondents reported to have more positive attitude towards Western healing system exclusively and an equal percentage of respondents claimed to have more positive attitude towards traditional healing system exclusively.

The majority of the respondents claimed that, traditional healers deal more satisfactorily and effectively with culture bound and mostly supernatural caused illness, while Western healing system is effectively dealing more with naturally caused and physiological illness. This was reported by about 78.13% of the respondents, and 21.87% of them claimed that, both systems can satisfactorily and efficiently deal with almost all illnesses equally.

46.88% of the respondents favoured dual consultation. The same will also advice either their next of kin and/or friend to consult both systems in cases of mental illness or psychological illness. 28.12% favoured Western healing system and 25% favoured traditional healing system. This differs with the hypothesis that, Black communities will consult more

to traditional healers than to Western healers, in cases of mental pathology; but has been envisaged, dual or concurrent consultation is also favoured.

The percentage that favours Western healing, explains it to be somehow more technologically and technically advanced and their practitioners have undergone some extensive training in different healing and treatment procedures, particularly in physiological illness and in those illness where surgery is mandatory. On the other hand, those that have more preference for traditional healing system, explain it to be more culturally relevant to the Black population and tends to be more sensible in diagnosing different illness (explaining the "Why" and the "How" in the cause of illness).

The majority of the respondents, 78.13% reported to have full confidence in the success of traditional healing in treating mental or psychological illnesses, as compared to 21.87% of the respondents who appeared to be somehow doubtful in their success, and claiming that traditional healing might be more successful in treating culture bound and supernatural caused illnesses.

46.88% of the respondents reported that traditional healing services are more equitable to the community than is Western healing, while 43.75% had the opposite view, and reported Western healing services as being more equitable than traditional healing services. Only 9.37% of the respondents claimed both healing services as being equally equitable to the community.

All the respondents (100%) showed preference for the merger of the two healing systems in the treatment of different mental or psychological illnesses. The respondents felt that the two must be equally recognised and put into the formal national health system.

The majority of the respondents, 78.12% reported culture bound and mostly supernatural caused illnesses, including mental illness as the type of illnesses that they can consult or advice the next person to consult traditional healing system for. Others claimed other illnesses like sexually transmitted diseases (STD) and infertility.

Some respondents (about 25%)claimed that traditional healing is slow in its treatment than is the case with Western healing system, thus in cases

of emergency and in acute cases, preference is put on consulting to Western system first before going to traditional system.

In broad overview the majority of the respondents have more positive beliefs towards dual consultation of both traditional and Western systems, and hence have equally the same attitude towards the Western and traditional healing systems jointly. The majority has full confidence in the success of traditional healing in treating different illnesses and particularly mental or psychological illnesses.

For the rural and urban population, the majority of the respondents in therural sample favours traditional healing more than Western healing and 93.75% of the rural respondents compared to 62.5% of the urban respondents showed full confidence in the success of the traditional healing in treating mental illness (see figure 1). This tally with the hypothesis that, people from rural or semi-rural areas will more likely have positive beliefs towards traditional healing and hence consult more to them than to Western healing system. However according to the computed Chi- square test(X^2 = 2.926 and 2.457, df = 1, $\propto$ = 0.05) there is no significant difference between the two sample's beliefs and

consultation of either traditional or Western healing systems (see Appendices C and D).

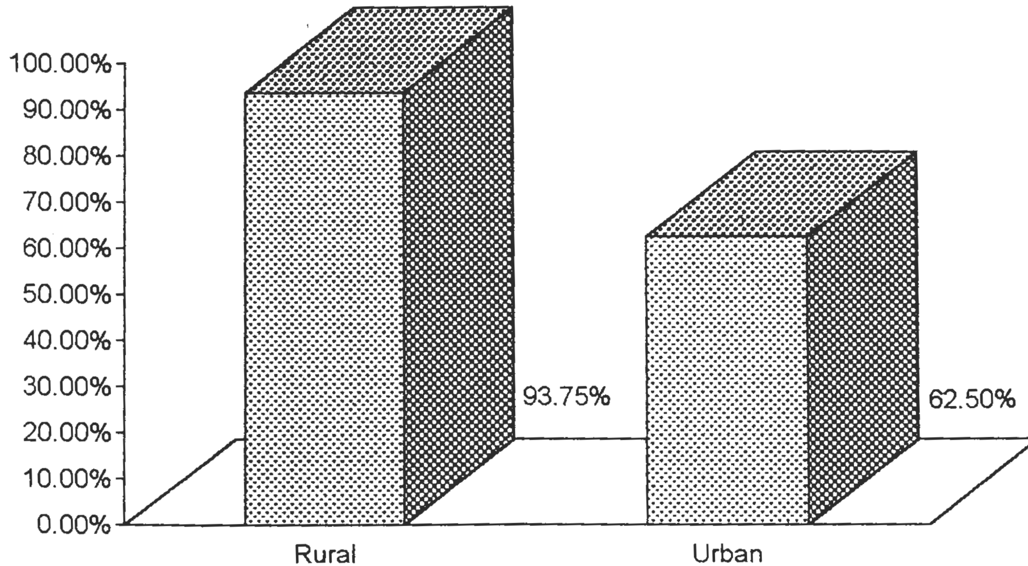

Fig. 1: Figure showing the percentages of rural and urban sample's confidence in traditional healing.

The majority of male respondents in both rural and urban samples showed more positive beliefs towards traditional healing system than it is with female respondents, even if the difference is not that significant according to the computed X^2-test ($X^2 = 0$ and 1.418, $df = 1, \propto = 0.05$) (see Appendices E and F). 50% of male respondents showed preference for the consultation of traditional healing particularly in mental illness,

with only 12.5% of female respondents preferring traditional healing (see table 2). This somehow disconfirms the hypothesis that, there will be a significant difference in attitudes and consultation patterns across the gender characteristic of the community; However in overall both samples showed a positive stand towards the collaboration of both health systems.

Table 2: Table of percentages of beliefs and practices of male and female samples in mental illness.

	MALE	FEMALE
Consulted a Traditional healer before	93.75%	81.25%
Never consulted a Traditional healer before	6.25%	18.75%
Consulted a Traditional healer first then later consulted a Western healer	53.33%	15.39%
Consulted Western healing first	46.67%	84.6l%
Equally positive to both Traditional and Western healing systems	68.75%	56.25%
More positive towards Traditional healing than Western	25%	0

healing system		
More positive towards Western healing than Traditional healing system	6.25%	43.75%
Favours consulting to Traditional healing in cases of mental illness	31.25%	18.75%
Favours consulting to Western healing in cases of mental illness	12.5%	50%
Favours dual consultation in cases of mental illness	50%	0
Full confidence in the capabilities of Traditional healing	81.25%	75%
Doubts in the capabilities of Traditional healing	12.5%	12.5%
Claim Traditional healing to be more accessible than Western healing system	56.25%	31.25%
Claim Western healing to be more accessible than Traditional healing system	25%	62.5%

The table consists of percentages observed according to the different themes. Each theme consists of average percentage of respondent's opinions.

There was a slight difference in the beliefs and practices between rural and urban female samples. A preponderance of the sample in the rural area had consulted the traditional healer more than it was the case in an urban area (see figure 2).

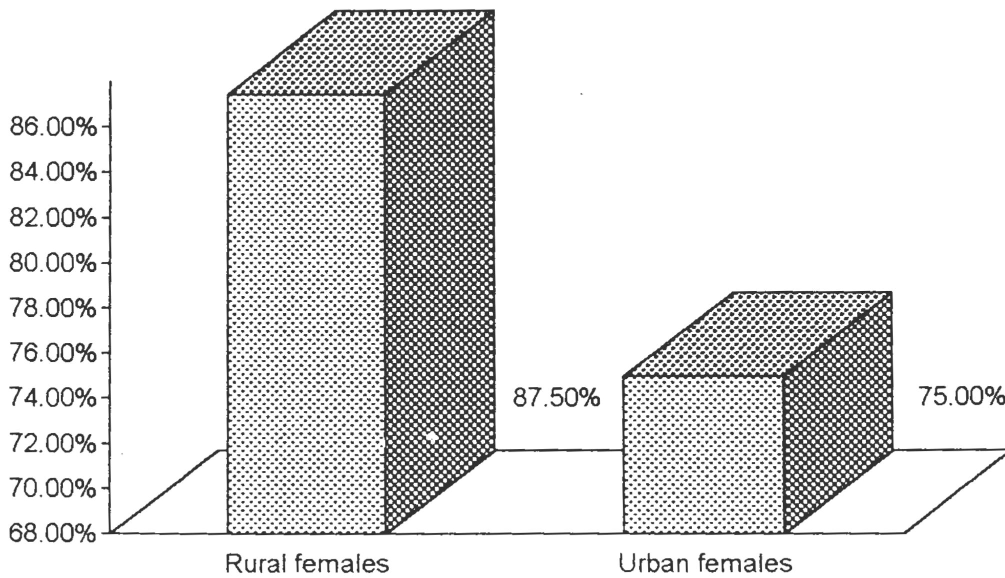

Fig. 2. Figure of consultation patterns of rural and urban females in terms of traditional healing.

100% of the sample from the rural area reported to have full confidence in the success of traditional healing in treating mental illness, as compared to 50% of the urban female sample (see Figufre 3).

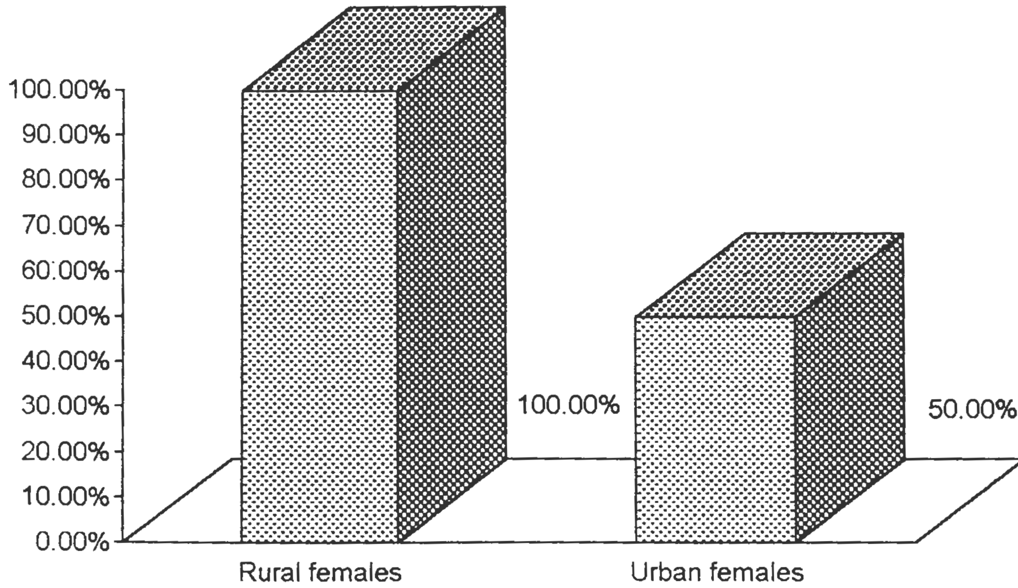

Fig. 3.: Figure showing the percentages of rural and urban females showing confidence in the capabilities of traditional healers in treating mental illness.

The majority of both males and females in the age group 18-40 years, have consulted the traditional healer and were confident in his/her success of resolving problems associated with mental illness (see table 2). Significantly in the sample drawn for this study, it was the traditional healer who was consulted first in cases of any type of illness.

A higher percentage of older population (age 40 years and above) agreed to have used traditional services before, while a lesser percentage in the younger age group sample (age 18-40 years) had reported the same (see table 3). This confirms the hypothesis that, there will be a difference in the beliefs and practices of respondents according to age difference, towards mental illness and traditional healing. However the difference is regarded not to be significant according to the computed chi-square test (X^2 = 0 and 0.66, df = 1, $\propto$ = 0.05) (see Appendices G and H).

Note: All the tables appearing below, show the average percentages of respondents according to the different themes as they appear in the different tables. The average percentages corresponds with the identified samples as indicated in the different tables.

TABLE 3.: Table showing beliefs and practices of younger and older age group samples in cases of mental illness.

	18 -40 yrs	40 yrs ⇑
Consulted a Traditional healer before	75%	100%
Consulted a Traditional healer first before Western system	41.67%	37.5%
Consulted Western healer first	58.33%	62.5%
More positive towards Traditional healing	6.25%	18.75%
More positive towards Western healing	31.25%	18.75%
Full confidence in the capabilities of Traditional healing in mental illness	81.25%	75%
Doubts in the capabilities of Traditional healing in cases of mental illness	6.25%	18.75%
Favours the consultation of Traditional healing system in cases of mental illness	31.25%	18.75%
Favours the consultation of Western healing system in cases of mental illness	25%	37.5%

The majority of rural younger age group sample, showed a much higher preference in the consultation of traditional healing, particularly in cases of mental illness, as compared to the younger age group sample from the urban area. All the respondents (100%) from the rural younger age group sample, showed a full confidence in the success of traditional healing in solving mental health problems; whereas 62.5% from the urban younger age group sample citing the same sentiments (see table 4).

TABLE 4.: Table showing percentages of beliefs and practices of rural and urban younger age group sample in cases of mental illness.

	Rural 18 -40 yrs	urban 18 - 40 yrs
Consulted a Traditional healer before	75%	75%
Consulted a Traditional healer first before Western system	50%	50%
Consulted Western healer first	50%	50%
More positive towards Traditional healing	25%	0
More positive towards Western healing	12.5%	37.5%

Full confidence in the capabilities of Traditional healing in mental illness	100%	62.5%
Doubts in the capabilities of Traditional healing in cases of mental illness	o	12.5%
Favours the consultation of Traditional healing system in cases of mental illness	62.5%	0
Favours the consultation of Western healing system in cases of mental illness	25%	25%

There is also a slight difference in the preferences and practices between urban male sample and rural male sample. The majority of the rural male sample (50%), prefer the consultation of traditional healing system, while only 12. 5% from the urban sample preferring traditional healing consultation. 87.5% of the rural male sample showed full confidence in the success of traditional healing in mental illness, as compared to 75% of the urban male sample (see table 5).

TABLE 5.: Table showing the beliefs and practices of rural and urban males in cases of mental illness.

	rural males	urban males
Consulted a Traditional healer before	87.5%	100%
Consulted a Traditional healer first before Western	71.43%	37.5%
Consulted Western healer first	28.57%	62.5%
More positive towards Traditional healing	37.5%	12.5%
More positive towards Western healing	0	12.5%
Full confidence in the capabilities of Traditional healing in mental illness	87.5%	75%
Doubts in the capabilities of Traditional healing in cases of mental illness	0	25%
Favours the consultation of Traditional healing system in cases of mental illness	50%	12.5%
Favours the consultation of Western healing system in cases of mental illness	12.5%	12.5%

There are some differences in beliefs and practices between the younger and older populations within the rural population, with the younger sample having more positive beliefs and preferring the consultation of traditional medicine than that of Western healing system, particularly in mental illness (see table 6). However this trend was not found in the urban younger and older samples.

TABLE 6.: Table showing the beliefs and practices of rural younger and older age group samples in cases of mental illness.

	rural 18-40 yrs	rural 40 yrs & above
Consulted a Traditional healer before	75%	100%
Consulted a Traditional healer first before Western system	50%	37.5%
Consulted Western healer first	50%	62.5%
More positive towards Traditional healing	25%	25%
More positive towards Western healing	12.5%	0
Full confidence in the capabilities of Traditional	100%	87.5%

healing in mental illness		
Doubts in the capabilities of Traditional healing in cases of mental illness	o	0
Favours the consultation of Traditional healing system in cases of mental illness	62.5%	25%
Favours the consultation of Western healing system in cases of mental illness	25%	25%

In summary the findings show that the sampled respondents have more positive opinion in the merger of both the Traditional and Western healing systems. Although they showed somewhat lesser preference in them consulting the traditional healer. They however showed more confidence in the capabilities of traditional healing in treating different illnesses. This can be accounted for by the level of Westernization as well as their religious values. There were no significant differences found in the beliefs and practices of the sampled respondents, according to the differences in their sociodemographic factors.

CHAPTER FIVE

5. DISCUSSION

5.1 GENERAL DISCUSSION

The present study showed that, the black population in general within Mmabatho and surrounding rural areas has more positive beliefs towards both Traditional and Western healing systems jointly. A majority of the sampled respondents favoured the merger between the two healing systems. These results are consistent with the findings of Oberholzer (1985), that the community of Odi-1 district (that is, Garankuwa and surrounding areas; which also falls within the North West province, with inhabitants being mostly Batswana) who require psychiatric attention, consult both the Traditional and the Western healers.

Dual consultation or treatment was found to be the treatment of choice amongst both groups (rural and urban samples). However traditional theories and practices concerning illness in general and mental illness in particular are still pervasive, often in the form of adjunctive beliefs and practices (Hadebe, 1986). This was further verified by the majority of

responses (96.88%), that cited supernatural factors as causing mental illness; mostly sorcery, witchcraft and failure to adhere to cultural taboos as some of the factors.

This phenomenon of dual utilisation is significant because it provides a basis for tying traditional and Western medicine, of which is one of the priorities in the National health plan (1994), that the government will also seek to establish appropriate mechanisms that will lead to the integration of traditional and other complementary healers into the National health system, with the aim of attaining "health for all" in South Africa and representativity of practitioners.

The present study lent support to previous studies which indicated that, traditional African health practices still thrive in South Africa. The majority of the respondents reported to have utilised the services of traditional healers previously (87.5%) and about 78.13% of the respondents reported to have full confidence in the success of traditional healing in the treatment of mental or psychological illnesses. In view of this resilience of a practice that is deeply rooted in the culture of the indigenous people of South Africa, it is apparent that some form of recognition of traditional healing is desirable (Sodi, 1987).

However in contrast, a lesser percentage of the respondents (25%) claimed to prefer the consultation of traditional healing in the future, particularly in cases of mental illness. This reflects the ambivalence on the part of some respondents to publicly admit that they consult traditional healers. This contrast might be accounted for by "self preservation as Makwe (1985) view it. He maintained that, self preservation is a problem that continues to manifest itself as a consistent difficulty in most studies, that is, inconsistency in results, due to answers given to gain approval or impress the interviewer, is not uncommon, for example, though many people consult indigenous agents, they do not like to admit it.

This shows that even though most of the people particularly in the urban areas claim not to prefer traditional healers exclusively, but they however showed a high sense of confidence in their capability in treating mental illness. This may also prove right the notion that, most people are reluctant or tends not to overtly associate themselves with traditional healing, but in fact covertly making an extensive utilisation Of their services.

In cases of whether respondents started consulting either traditional or Western healing systems previously. The majority of the respondents (56.25%) reported to have started consulting in Western healing system before and then later resorted to traditional healing. Their reasons were mostly that, they were not successfully treated in Western system. This is explained by Bodibe (1989) that, Blacks use traditional healers because it is believed that Western healers cannot heal all the diseases and what is more, certain blacks believe that there are diseases that afflict Blacks only (culture-bound) and therefore cannot be ameliorated by Western medicine. This could be related to a belief in the supernatural causation of illness and illness that are said to be culture-bound or culture related.

These findings tally with the high responses in the present study (78.13%), that traditional healers deal more satisfactorily and efficiently with healing system is effectively dealing more successfully with naturally caused and physiological illnesses.

The study then confirms the view of Fernando (1991) that, the more convinced the mentally ill person is, that his/her illness has been caused

by unnatural factors, the more likely it is that he/she will first seek help in traditional healing. On the other hand O'Connel (1980) as cited by Mabetoa (1994), remonstrated that Psychologists know that "Thwasa" and other culture-bound illnesses cannot be cured with the usual forms of psychotherapy.

In the rural and urban areas, results showed that the majority of both samples favoured Traditional healing more than Western healing. 93.75% and 62.5% respectively showed full confidence in the capability of traditional healing in the treatment of mental illness. This indicated to us that, traditional healing is not for rural Blacks only but urban Blacks also use its services. However the higher percentage of respondents in urban areas who consulted more to Western healing system initially, before they could resort to traditional healing (71.43%), might be accounted for by the degree of urbanisation and easy accessibility of Western healing services in their areas. In overall, this also indicates that people look for alternatives in health care.

Pertaining to the gender characteristic, a majority of male respondents (50%) showed more positive beliefs to traditional healing than is the case

with the female sample (12.5%), even though the results were not statistically significant. This may mean that males in most cases have more faith in traditional healing than females and in most cases, firstly consult with traditional healing than is the case with females. This however is not consistent with the study conducted by Makwe (1985), which showed that men tended to go in more for scientific or Western health care.

One interesting finding in the present study was that, the majority in the younger age group sample (18-40 years) showed more positive beliefs and consultation patterns towards traditional healing, than is the case in the older age group sample (40 years and above). This also goes against the assumption according to Snyman (1992) that, older persons with traditional life-styles and low education levels turned out to be the largest consumers of the traditional healer's services. However this might go along with the notion of cultural renaissance, of which the younger generation might be the proponents of.

The issue of payment in cases of equitability or accessibility of health services was raised. This pertain to the utilisation of medical aid

schemes that make it easier for people to access to Western healing systems than to traditional healing system, particularly in the urban areas.

Concern was also raised about crafty charlatans or "quack" practitioners who might not be true traditional healers and who can cause more harm than good to the community. This is said against the background that traditional healing is a call or "talent" from the ancestors; thus these "quack" Doctors might not have been called by ancestors, the assumption that, they might also be involved in sorcery and witchcraft. This and the above concerns are thought to can be solved by the registration of traditional healers in some sort of health council or association. This will help to monitor their services and for the protection of the public or consumers.

5.2 VIEWS FROM TRADITIONAL HEALERS

In a workshop/summit that was held by the provincial department of health together with the traditional healers, at Mmabatho on the 26th October 1998; The following sentiments and views were unanimously expressed by the traditional healers:-

- collaboration and/or co-operation was more favoured than integration. The formula that was proposed is not a mixture of discrete elements borrowed from the two medical systems, but rather a harmonising of two medical practices operating within its own sphere and each renewing and enriching itself and the other.

- The government should establish a centralised health centre where all traditional healers with their different specialisation, can be accessed to by the community. While others may be allowed to work from their places, where they feel they get power from their ancestors "Ndumba".

- Training centres for traditional healers should also be established.
- Traditional healers should be recognised legally and be subsidised for their community services. The government should help in the provision of resources and infrastructure for traditional healing system, to enhance the provision of better health care delivery by traditional healers, (for example, transportation).

- There should be regular meetings and workshops between practitioners of both healing systems. Referral system be upgraded and respect be shown to practitioners of both healing systems.

- A post of a traditional healer as a liaison officer within the managerial sect of the health department be created, both provincially and nationally, to ensure a better representation and recognition of traditional healing in government.

The Department of health's response to the forwarded recommendations were that:-

It has envisaged to encourage traditional healers in establishing a single Interim council of traditional healers, where all traditional healers will be registered. The council shall be of equal status with the Health Professions Council of South Africa (H P C S A). (Presently in the North West there exists two organisations for traditional healers, which were in existence during the Bophuthatswana era:- The Dingaka Association and the Traditional Healers Organisation (T.H.O)).

Traditional healers should categorise themselves in accordance to their specialities and capabilities, to enhance better collaboration and efficacy of health care delivery.

5.3 CONNECTING TRADITIONAL AND WESTERN MEDICINE

Africans have a dualistic outlook on life which accommodates both the conspiracy theory of witchcraft and the "scientific" theory of modern or Western medicine. In order to create a new syncretic type of national health-care delivery system, traditional medicine can be made relevant and its efficacy increased by means of either complementary or integration (Snyman, 1992)

5.3.1 Co-operation/Collaboration

In this option both the Traditional and Western systems remain essentially autonomous and each retains its own methods of operation and explanation. Both paradigms would recognise the efficacy of the other in the treatment of particular disorders and would thus refer to each other in the appropriate circumstances (Green & Makhubu, 1984, Cited by Fenyves, 1994). Practitioners would come to an agreement as to what disorders should be referred to whom. Co-operation implies a better working relationship between two sectors.

5.3.2 Integration

The World Health Organisation (1978) describes effective integration as a synthesis of the merits of traditional and modern medicine by implementing modern scientific knowledge and techniques. The underlying assumption is that the characteristic skills of certain traditional healers can be adapted effectively in order that these healers receive appropriate training to be able to cope with certain modern practices and to transmit certain modern medical beliefs.

5.4 LIMITATIONS OF THE STUDY

As an exploratory study the present study had many limitations in assessing the beliefs and practices in mental illness in rural and urban samples. First, the study was limited to Setswana speaking respondents and exclusively in the North West province. Therefore the information obtained in this study can not be representative of other population groups in South Africa, that is, generalizability will be compromised.

Secondly, other respondents might hide their true beliefs and practices, since the traditional healing system has been misconstrued to be "inferior" and associated with negative colonial connotations, following

colonial legacy; also the influence of "self preservation" as was noted by Makwe (1985).

Thirdly, the method of data collection also had its practical limitations. Translation of the questions from English to Setswana may have influenced responses.

One limitation of an interview is the interviewer bias where responses are mediated by interviewer characteristics or other demands characteristic of the situation (Phares, 1984). Although the interviews in this study were structured, the interviewer's idiosyncratic personal or attitudinal characteristics might have influenced their behaviour, and thus in turn prompted the participants to respond differently.

CHAPTER SIX

6. CONCLUSION AND RECOMMENDATIONS

6.1 CONCLUSION

The study explored the beliefs and practices in mental illness in a rural and urban samples in Mafikeng and surrounding areas. Differences in beliefs and practices according to the sociodemographic differences were also explored. One purpose of the study was to see whether it is conducive and acceptable to merge both Traditional and Western healing systems, in the formal health care system of the country, to help realise the goal of "health for all" in South Africa.

The present study supports the findings of the study made by Hopa et al. (1995), that the consumers of health care, had a positive attitude towards integration although they also expressed some concern about bogus traditional healers. The question is thus whether the present provision of health care in South Africa really lends itself to a fair distribution which is commensurate with the actual health needs of the population.

It was pointed out in the study that, many Africans cited psychological conditions or mental illness as being caused by supernatural and cultural factors, which are not understood by Western doctors, but which traditional healers can and do cure. The above, together with the high traditional healer : population ratio, brings the researcher to the conclusion that traditional healing still enjoys a fair amount of acceptability in the Black population. The need for the traditional healers to be recognised and to be made part of the official health care system in South Africa cannot therefore be overemphasised.

The results also showed that there are no significant differences in beliefs and practices of the community regarding mental illness and intervention preferences in accordance to the differences in sociodemographic factors (that is, demographic location, gender and age).

Consumers are currently often torn between the two systems of health care, a dilemma which could be removed by linkage. The contribution that traditional healing could make to the mental health of the African in particular, can be missed entirely if Western therapeutic approaches are

the only ones used to control health problems (Bodibe, 1992). Snyman (1992) also emphasised that, if the principle is accepted that what the therapy patients receive, should be in accordance with their culture and world-view, traditional medicine cannot be phased out in the near future.

It is hoped that the study will contribute to action and dialogue between the practitioners of both healing systems, prompting mechanisms for co-operation and thus ensuring maximum results from the National Health Plan. Indeed it should be considered that even patients presenting with mental health problems in the Western health services, be given the choice of using either a traditional or a "scientific" healer or both depending on his/her preference.

6.2 RECOMMENDATIONS

The relatively widespread usage of traditional medicine, alone or in combination with modern (Western) medicine, and the research findings mentioned above, seem to warrant greater integration or co-operation of Western and traditional healing systems as has been advocated in neighbouring Swaziland, Zimbabwe and Zambia, to mention but a few.

Airhinhenbuwa (1995) is also of the view that, as long as Africans successfully seek treatment from both Western and Traditional healers, it is prudent to strive for mutual collaboration based on respect and trust between the two types of health providers.

Certainly both systems have a lot to offer each other and a lot to learn from each other (Edwards, 1992).Strake (1994) and Maclachlan et al.(1995) also emphasised that, there is increasing support for the idea that the health services of developing countries may be sustained more effectively by integrating these two approaches to therapy. It has become one of the priority health care activities in the department of Psychiatry at MENDUSA to involve the communication of traditional healers in the mental health care process as an attempt to provide an extended, more effective, practical, cost appropriate, socially acceptable health service for the population.

A forum should be created for constant frank dialogue between the practitioners of both approaches, to serve as a basis for establishing mutual trust, confidence and to dispel misconceptions and suspicions as well as facilitating reciprocal learning between these groups. This could

be achieved in the form of conferences, workshops, symposia and discussion groups.

Reciprocal referral should be encouraged between the traditional and Western practitioners to demonstrate the true beginning of division of labour and teamwork in action. The use of traditional healers, could form the basis of understanding the culture of African people which is essential in carrying out any form of treatment and/or health education.

University curricula in Medicine and Psychology should incorporate courses on the study of African culture and indigenous healing. In their final years (or internship) students in these fields should be placed in the homes of traditional healers, so as to observe and seize the therapeutic milieu experientially. These placements could only happen if traditional healers are recognised and accorded their rightful place in the health care system.

An umbrella body should be established to co-ordinate all the traditional healers associations in the country. Such an umbrella body could function like and in association with the H P C S A .

Centres along the lines of H.S.R.C and the South African Institute of medical Research, should be established throughout the country to carry out research and to serve as resource centres about indigenous healing. Scholars interested in the field should be encouraged and sponsored by such centres and the government.

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APPENDIX A: RESEARCH INSTRUMENT

INTERVIEW QUESTIONS

ENGLISH VERSION

INTERVIEW

A. GEOGRAPHICAL INFORMATION

House Number:

Urban / Village:

B. BIOGRAPHICAL INFORMATION

1. When were you born ? Age
2. Sex: Male or Female ?
3. To which ethnic group do you belong ?
4. Marital status ?(Are you married ?)
5. What level of education did you attain ?
6. To which church do you belong to ?
7. Type of occupation ?(What type of work do you do ?)
8. How far are you to the nearest medical service ? (e.g. Clinic)

C. MAIN INTERVIEW

1. In your opinion, what causes or brings about mental illness ?
2. In what way do you think mental illness can be treated
3. How can you notice an individual with mental illness ?
4. Have you ever consulted a Traditional healer ?
5. Was it your decision to consult the healer or did someone else suggest that you do so ?
6. When you consulted the Traditional healer, was it before you consulted the Western trained doctor or after ? Why ?
7. What is your attitude towards Traditional and Western medicine ?
8. Are there specific illnesses that are dealt more satisfactorily by the Traditional healers and/or Western healers ?

9. Do you think Traditional medicine is more relevant to Black Africans ?
   Why?
10. In cases of mental illness or psychological problem, what type of healing system will you consult or advice family members to consult ? Why ?
11. How successful do you think the Traditional healer is, in treating mental or psychological illness ?
12. In your opinion what type of healing system is more affordable, accessible and acceptable ?
13. What is your opinion for a merger between Traditional and Western medicine?
14. In what type of illness will you consult or advice a relative to consult the Traditional healing services ?
15. Anything else that you would like to mention about mental illness and/or Traditional healing system ?

APPENDIX B: RESEARCH INSTRUMENT

INTERVIEW QUESTIONS

CROSS TRANSLATION - SETSWANA VERSION

PATLISISO \ POTSOLOTSO

A. TSHEDIMOSETSO YA BONNO

Nomoro ya ntlo:

Motsetoropo \ Motse:

B. TSHEDIMOSETSO KA GA GAGO

1. O belegwe \ tsetswe leng? Bogolo?
2. Bong: Monna kgotsa Mosadi?
3. O tokololo ya morafe ofe?
4. Maemo a nyalo: (A o nyetse \ nyetswe)?
5. Maemo a gago a thuto ke afe?
6. O tokololo ya kereke efe?
7. Mofuta wa tiro: (O dira tiro ya mofuta ofe)?
8. O kgakala go le kae le tirelo ya kalafi e e gaufi nao? (sekai, Kliniki)

C. PATLISISO TOTA

1. Go ya ka wena, ke eng se se bakang bolwetse ba tlhaloganyo?
2. O akanya gore bolwetse ba tlhaloganyo bo ka alafiwa jang?
3. O ka lemoga jang gore motho o na le bolwetse bo tlhaloganyo?
4. A o kile wa ya ngakeng ya setso?
5. A e ne e le tshwetso ya gago go ya ngakeng e, kgotsa o tlhagisitswe ke mongwe go dira jalo?
6. Fa o ne o ya kwa ngakeng ya setso, a e ne e le pele ga go ya kwa ngakeng ya sekgoa kgotsa morago ga fao? Go reng?
7. Maikutlo a gago ke afe mabapi le kalafi ya sekgoa le ya setso?

8. A go malwetse a a rileng a a alafiwang sentle ke dingaka tsa setso kgotsa dingaka tsa sekgoa?
9. A o akanya gore kalafi ya setso e lebane thata bantsho ba Afrika? Go reng o akanya jalo?
10. Mo mabakeng a malwetse a tlhaloganyo kgotsa matshwenyego a semowa, o ka batla thuso, kgotsa o ka gakolola ba lelapa la gago, ba losika gotsa tsala go batla thuso ya kalafi ya mofuta ofe? Go reng jalo?
11. O akanya gore ngaka ya setso e kgona go le kae, mo go alafeng malwetse a tlhaloganyo kgotsa a semowa?
12. Go ya ka wena ke mofuta ofe wa kalafi o o tlhotlhwa - tlase, kgotsa o o bonolo go fitlhelwa kgotsa o o amogelesegang?
13. O akanyang mabapi le go kopanngwa kgotsa go tshwaraganngwa ga kalafi ya setso le kalafi ya sekgoa?
14. Ke mabapi le bolwetse ba mofuta ofe bo o ka yang kgotsa bo o ka gakololang wa losika gotsa tsala go ya ngakeng ya setso?
15. Ke eng gape se o ka ratang go se tlhagisa mabapi le bolwetse ba tlhaloganyo le \ kgotsa bongaka ba setso?

APPENDIX C:

COMPARISON OF RURAL AND URBAN SAMPLES IN BELIEFS TOWARDS THE CAPABILITIES OF TRADITIONAL HEALERS

GEOGRAPHICAL LOCATION	RURAL	URBAN	TOTAL
POSITIVE	(A) 15	(B) 10	25
NEGATIVE	© 1	(D) 6	7
TOTAL	16	16	32

$$X^2 = \frac{N(|AD - BC| - \frac{1}{2} N)^2}{(A + B)(C + D)(A + C)(B + D)}$$

$$= \frac{32(|90 - 10| - 16)^2}{(25)(7)(16)(16)}$$

$$= \frac{32(80 - 16)^2}{44800}$$

$$= \frac{32 \times 4096}{44800}$$

$$= \frac{131072}{44800}$$

X^2 Obs. = 2.926

df = (K - 1)(H - 1)

$= (2 - 1)(2 - 1)$

$= 1$

$\alpha = .05$

X^2 Crit. = 3.841

CONCLUSION: THERE IS NO SIGNIFICANT DIFFERENCE BETWEEN RURAL AND URBAN SAMPLES.

APPENDIX D

COMPARISON OF RURAL AND URBAN SAMPLES IN CONSULTATION PATTERNS IN CASES OF MENTAL ILLNESS.

GEOGRAPHICAL LOCATION	RURAL	URBAN	TOTAL
TRADITIONAL HEALING	(A) 7	(B) 1	8
WESTERN HEALING	© 4	(D) 6	10
TOTAL	11	7	18

$$X^2 = \frac{N(|AD - BC| - \frac{1}{2} N)^2}{(A + B)(C + D)(A + C)(B + D)}$$

$$= \frac{18(|42 - 4| - 9)^2}{(8)(10)(11)(7)}$$

$$= \frac{18(38 - 9)^2}{6160}$$

$$= \frac{18 \text{ X } 841}{6160}$$

$$= \frac{15138}{6160}$$

X^2 Obs. = 2.457

df = (K - 1)(H - 1)

= (2 -1)(2 - 1)

= 1

$\propto$ = .05

X^2 Crit. = 3.841

CONCLUSION: THERE IS NO SIGNIFICANT DIFFERENCE BETWEEN RURAL AND URBAN SAMPLES.

APPENDIX E

COMPARISON OF MALE AND FEMALE SAMPLES IN BELIEFS TOWARDS THE CAPABILITIES OF TRADITIONAL HEALERS

GENDER	FEMALES	MALES	TOTAL
POSITIVE	(A) 12	(B) 13	25
NEGATIVE	© 4	(D) 3	7
TOTAL	16	16	32

$$X^2 = \frac{N(|AD - BC| - \tfrac{1}{2} N)^2}{(A + B)(C + D)(A + C)(B + D)}$$

$$= \frac{32(|36 - 52| - 16)^2}{(25)(7)(16)(16)}$$

$$= \frac{32(16 - 16)^2}{44800}$$

$$= \frac{32 \text{ X } 0}{44800}$$

$$= \frac{0}{44800}$$

X^2 Obs. = 0

$$df = (K - 1)(H - 1)$$

$$= (2 - 1)(2 - 1)$$

= 1

$\propto = .05$

X^2 Crit. = 3.841

CONCLUSION: THERE IS NO SIGNIFICANT DIFFERENCE BETWEEN MALE AND FEMALE SAMPLES.

APPENDIX F

COMPARISON OF MALE AND FEMALE SAMPLES IN CONSULTATION PATTERNS IN CASES OF MENTAL ILLNESS

GENDER	FEMALES	MALES	TOTAL
TRADITIONAL HEALING	(A) 3	(B) 5	8
WESTERN HEALING	© 7	(D) 2	9
TOTAL	10	7	17

$$X^2 = \frac{N(|AD - BC| - \frac{1}{2} N)^2}{(A + B)(C + D)(A + C)(B + D)}$$

$$= \frac{17(|6 - 35| - 8.5)^2}{(8)(9)(10)(7)}$$

$$= \frac{17(29 - 8.5)^2}{5040}$$

$$= \frac{17 \text{ X } 420.25}{5040}$$

$$= \frac{7144.25}{5040}$$

X^2 Obs. = 1.418

$df = (K - 1)(H - 1)$

$= (2 - 1)(2 - 1)$
$= 1$

$\alpha = .05$

X^2 Crit. = 3.841

CONCLUSION: THERE IS NO SIGNIFICANT DIFFERENCE BETWEEN THE MALE AND FEMALE SAMPLES.

APPENDIX G

COMPARISON OF YOUNGER AND OLDER AGE GROUP SAMPLES IN BELIEFS TOWARDS THE CAPABILITIES OF TRADITIONAL HEALERS

AGE	YOUNGER AGE GROUP(18 - 40yrs)	OLDER AGE GROUP(40yrs and above)	TOTAL
POSITIVE	(A) 13	(B) 12	25
NEGATIVE	© 3	(D) 4	7
TOTAL	16	16	32

$$X^2 = \frac{N(|AD - BC| - \frac{1}{2} N)^2}{(A + B)(C + D)(A + C)(B + D)}$$

$$= \frac{32(|52 - 36| - 16)^2}{(25)(7)(16)(16)}$$

$$= \frac{32(16 - 16)^2}{44800}$$

$$= \frac{32 \times 0}{44800}$$

$$= \frac{0}{44800}$$

X^2 Obs. = 0

df = (K - 1)(H - 1)

= (2 -1)(2 - 1)

= 1

$\propto$ = .05

X^2 Crit. = 3.841

CONCLUSION: THERE IS NO SIGNIFICANT DIFFERENCE BETWEEN THE YOUNGER AND THE OLDER AGE GROUP SAMPLES.

APPENDIX H

COMPARISON OF YOUNGER AND OLDER AGE GROUP SAMPLES IN CONSULTATION PATTERNS IN CASES OF MENTAL ILLNESS

AGE	YOUNGER AGE GROUP(18 - 40yrs)	OLDER AGE GROUP(40yrs and above)	TOTAL
TRADITIONAL HEALING	(A) 5	(B) 3	8
WESTERN HEALING	© 4	(D) 5	9
TOTAL	9	8	17

$$X^2 = \frac{N(|AD - BC| - \frac{1}{2} N)^2}{(A + B)(C + D)(A + C)(B + D)}$$

$$= \frac{17(|25 - 12| - 8.5)^2}{(8)(9)(9)(8)}$$

$$= \frac{17(13 - 8.5)^2}{5184}$$

$$= \frac{17 \times 20.25}{5184}$$

$$= \frac{344.25}{5184}$$

X^2 Obs. = 0.66

df = (K - 1)(H - 1)

= (2 -1)(2 - 1)

= 1

$\propto$ = .05

X^2 Crit. = 3.841

CONCLUSION: THERE IS NO SIGNIFICANT DIFFERENCE BETWEEN THE YOUNGER AND THE OLDER AGE GROUP SAMPLES.