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Discourses of Psychiatry and Culture: The Interface Between Western and Traditional Medicine in the Treatment of Mental Illness

Madeline Molot
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DISCOURSES OF PSYCHIATRY AND CULTURE: THE INTERFACE BETWEEN WESTERN AND TRADITIONAL MEDICINE IN THE TREATMENT OF MENTAL ILLNESS

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SIT Durban: Community Health and Social Policy, Spring 2017
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Abstract

Mental illness is a burden of disease that, in many countries, is neglected; South Africa is no exception. There are many reasons for this, including but not limited to a lack of specialized mental health personnel in primary care settings, a budget that favors South Africa’s communicable disease epidemic, and a continued stigma around mental illness. Whenever discussing the healthcare system in South Africa, however, it is important to note another parallel system of care, one with little to no budget or regulation: that of traditional healing. It is estimated that over 70% of South Africans have at some point consulted a traditional healer, and, particularly in rural areas, traditional healers outnumber doctors 10:1. Traditional healers treat a wide range of illnesses, mental illness included.

Therefore, through this project, I aimed to gain a greater understanding of traditional healers’ conceptualizations of mental illness and investigate how biomedical practitioners understand and view this parallel healthcare system, in the hopes of obtaining some insight on the possibilities for the two fields to collaborate. To investigate these ideas, I utilized semi-structured interviews of both traditional healers and biomedical practitioners, and also presented traditional healers with case vignettes of particular mental illnesses for more specific and comparable responses using the Short Explanatory Model Interview (SEMI).

The results of this project showed that traditional healers do have an understanding of mental illness, but tend to classify psychotic disorders as being more exemplary of mental illness than non-psychotic disorders, which were more commonly understood to be ‘stress’. It also showed that there appear to be certain spiritual or culture-bound psychological illnesses that traditional healers are far better equipped to treat than Western practitioners, a fact which the Western practitioners understood and accepted. While both groups seemed willing to collaborate with each other and realized that doing so would be beneficial for many of their patients, they also acknowledged that there were currently very few avenues for this to occur in the context of mental health.
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Introduction

South Africa has eleven official languages, many of which come with their own unique traditions and cultures (South Africa History Online, 2015). Culture is complex and difficult to define, especially in such a diverse country as South Africa, often termed the “Rainbow Nation.” In 1871, poet, pastor, and physician Edward Taylor first defined culture as “that complex whole which includes knowledge, belief, art, law, morals, custom, and any other capabilities and habits acquired by man as a member of society” (Taylor, 1871, p. 1). Other academics have put forth different definitions: Margaret Mead defines culture as “the whole complex of traditional behavior which has been developed by the human race and is successively learned by each generation” (Mead, 1937, p. 17); Clifford Geertz writes, “[the culture concept] denotes a historically transmitted pattern of meanings embodied in symbols, a system of inherited conceptions expressed in symbolic forms by means of which [humans] communicate, perpetuate, and develop their knowledge about and attitudes toward life” (Geertz, 1966, p. 89).

Indeed, culture is multifaceted and has an influence on nearly every part of life: our knowledge systems, behaviors, morals, capacities for learning, and religious/spiritual beliefs. Therefore, culture must also influence the way in which we experience many aspects of both health and sickness. Depending on one’s culturally shaped belief system, disease can present itself in different ways; with this belief system comes varying perceptions of cause, diagnosis, and treatment. Cross-cultural psychiatry deals with this idea specifically in relation to mental illness; it attempts to understand how varying beliefs, psychosocial conditions, and interpersonal relationships may influence conceptualizations of mental illness, as well as how and why these conceptualizations differ between cultures (Kirmayer, 2006).

I first became interested in the influence of culture on sickness when I read Anne Fadiman’s novel, “The Spirit Catches You and You Fall Down: A Hmong Child, Her American Doctors, and the Collision of Two Cultures” (1997). The novel tells the story of Lia, a young Hmong girl living in California who suffers from seizures. While her doctors are sure the diagnosis is epilepsy—caused by the abnormal firing of brain cells—her parents are sure the diagnosis is the Hmong illness in which an evil spirit catches you—caused by soul loss. Both are absolutely sure of their diagnosis, and this, as one might expect, leads to clashes. Is one idea wrong and the other right, or can the two exist in tandem? Certainly, there is no simple answer. Cross-cultural psychiatrist Arthur Kleinman sheds some light onto this dilemma by distinguishing
two interrelated (but distinct) aspects of sickness: disease, “the malfunctioning or maladaptation of biological or psychological processes,” and illness, “the personal, interpersonal, and cultural reaction to disease” (Kleinman, 1977, p. 9). From a Western perspective, it would seem that in Lia’s case, her disease, epilepsy, was different from her illness, spirit possession and soul loss. And although her doctors and her parents tried desperately to understand the others’ perception of Lia’s sickness, major cultural, language, and systematic barriers limited them from working together as effectively as possible.

After reading Lia’s story, and being exposed to various cultures and belief systems here in South Africa, I became curious to see if similar cultural collisions would be present in a South African context, specifically in regard to mental health.¹ Thus, my main research question is: How do traditional healers conceptualize mental illness and how does this implicate collaboration/understanding between traditional and Western-trained practitioners? Sub-questions include: How important is the cause of sickness to the treatment of that sickness? What role does belief play in the psychology of traditional healing? What is the scope of Western-trained practitioners’ understanding about the ways in which traditional healers deal with mental illness? And what are the implications of this knowledge (or lack thereof) in closing or further widening the mental health gap in South Africa?

This project sought to explore these questions, despite the fact that some of them do not have clear answers, and/or cannot be fully answered given the limited scope and timeframe of this project. More generally, the aim of this project was to explore Zulu traditional healers’ conceptualizations of mental illness and by doing so, analyze the possibilities for more formal collaboration between the worlds of traditional healing and Western psychiatry. As a result, one would gain a greater understanding of the mental health gap in South Africa as well as of the ways in which culture and belief—compounded by a lack of dialogue between traditional and biomedical systems—may have contributed to that gap. Seeking answers to these questions is crucial to begin the process of closing the mental health gap in South Africa; indeed, traditional healing belief systems cannot be ignored but instead they must be appreciated and understood in order to foster a dialogue between Western and traditional healing disciplines.

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¹ As a neuroscience major, I’ve been taught the complexity of the human brain from a scientific perspective but have not been able to examine it in any kind of anthropological, spiritual, or cross-cultural setting.
**Context and Literature Review**

*The Mental Health Burden in South Africa*

The mental health burden in South Africa is high; a South African Stress and Health survey found that the lifetime prevalence of any common mental disorder was 30.3%, and that 11.7% of the population had more two or more disorders (Herman & Stein, 2009). Also relevant to the South African context is that there can be a link between poverty and the risk of mental illness (Patel & Kleinman, 2003). This relationship can be viewed as a vicious cycle: people living in poverty are at an increased risk of developing a mental disorder because of challenges such as lower education levels, poor housing, and food insecurity; those living with mental illness are far more likely to slide into poverty as a result of stigma and exclusion from social and economic opportunities (Patel, 2001; Skeen, Lund, Klientjes, & Flisher, 2010). And indeed, the province where this study was conducted—KwaZulu-Natal—is the third poorest in South Africa, with 69.1% of the population living below the poverty line as of the 2011 census (Statistics South Africa, 2014).

Mental disorders also display a large comorbidity with HIV, developmental disorders, epilepsy, and non-communicable diseases (Lund, 2015). The relationship between mental illness and HIV is incredibly pertinent in South Africa, a country with one of the highest HIV burdens in the world (UNAIDS, 2016). The connection between mental illness and HIV is also cyclical in nature; there is an increased vulnerability to HIV through mental illness-induced behaviors (for example, unsafe sex practices), and there is also a greater risk of developing a mental disorder (such as depression or anxiety) following a diagnosis of HIV (Skeen, Lund, Klientjes, & Flisher, 2010).

In part because of communicable disease epidemics such as HIV, very little of South Africa’s health budget is allocated to mental health: A 2007 World Health Organization (WHO) study found that while only three of the nine South African provinces were able to report on health expenditure on mental health, percentages ranged from only 1% (Northern Cape) to 8% (Mpumalanga) (World Health Organization, 2007). Access to mental health services is also scarce,

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2 In 2015, 19.2% of the adult population (ages 15-49) of South Africa was infected with HIV, which accounted for almost 20% of all persons infected with HIV globally (UNAIDS, 2016; Simela & Venter, 2014).
especially for relatively stable and chronic mental health disorders, which are mainly treated in community-based residential care facilities; a recent WHO analysis found that in Africa there are .08 residential care beds per 100,000 people, as compared to 6.30 in Europe (World Health Organization, 2014). Indeed, 77% of African countries’ mental health budgets are spent on resources for psychiatric hospitals, and “delivery of mental health care through primary care is either absent or fragmented” (World Health Organization, 2011; cited by Lund, et al., 2015, p. 234). Additionally, only one-quarter of the 16.5% of adults in South Africa who suffered from a common mental disorder in the last year received treatment for that disorder (Williams et al. (2008) and Stein et al. (2007), cited by Campbell-Hall & Petersen, 2010).

Traditional Healers in South Africa

In South Africa, more specifically in Zulu culture, there are three types of indigenous practitioners that fall under the umbrella of traditional healers: the herbalist (inyanga) who uses only herbal medicines, the diviner (isangoma) who uses a combination of communication with the ancestors and traditional medicine, and the faith healer (umthandazi) who mainly utilizes the power of prayer (Edwards, 2011; Kale, 1995). All of these practitioners apply some form of African traditional medicine (ATM), which is defined by the WHO as follows:

ATM is the sum total of knowledge and practices, whether explicable or not, used in diagnosis, prevention and elimination of physical, mental, or societal imbalance, and relying exclusively on practical experience and observation handed down from generation to generation, whether verbally or in writing (WHO, 2002; cited by Ngcobo, SIT Lecture Series 2017).

Traditional healers in South Africa are widely utilized and constitute what some call a parallel healthcare system (Kale, 1995). Not only do traditional healers outnumber medical doctors 10:1, but also it is estimated that 70% of South Africans consult traditional healers (Ngcobo, SIT Lecture Series 2017; Robertson, 2006).

Although the South Africa Health Act (1974) formally banned traditional healers under apartheid, they are now recognized under the Traditional Health Practitioners Act No. 22 of 2007. This act established the Interim Traditional Health Practitioners Council of South Africa and attempted to register and train traditional healers as well as provide a “regulatory framework to ensure the efficacy, safety, and control of traditional healing services” (Traditional Health Practitioners Act, 2007, p.2). Despite this, the Council was not actually established until 2013 and
so far has been unable to fulfill its mandate of registering traditional healers (Tshehla, 2015). Indeed, “to acknowledge a practice does not necessarily mean to endorse it,” and so in order to truly find a successful collaboration between traditional and biomedical practitioners, there must be more than simple acknowledgment and rather an increase in both understanding and respect (Woolf, 2003, p. 244; Moshabela, Zuma, & Gaede, 2016).

Zulu Concepts of Illness

While traditional healers are utilized across South Africa, the focus of this paper is on Zulu healers, specifically. Particularly in rural areas, Zulu beliefs and customs are still widely held, despite an increasing acceptance of Western medicine (Edwards, et al., 1983). Zulu concepts of illness mainly deal with cosmological forces, especially via ancestors or through forces of sorcery and bewitchment; however, many healers also possess distinction between theories of natural and of supernatural causation, known as umkhuhlane versus ukufa kwabantu (Ngubane, 1977). Umkhuhlane deals with illnesses of natural causation that ‘just happen’ whereas ukufa kwabantu illnesses have supernatural causes that are specific to African people (Ngubane, 1977).

Sorcery is one of these supernatural causes of illness and is used when a Zulu person bears a grudge against another person (Crawford & Lipsedge, 2004). Sorcery may cause or induce a variety of illnesses, including ‘stepping over’ illnesses (umeqo) in which the perpetrator puts the illness in the path of the victim, ‘eating’ illnesses (ukudlisa) which are caused by putting medicine in the victim’s food, and ‘throwing’ illnesses (ukuphonsa) which involve the use of a special traditional medicine mixture that can put the victim under a spell and induce hysteria (Crawford & Lipsedge, 2004).

The other major supernatural cause of illness usually originates from the ancestors, who are of supreme importance in Zulu culture (Crawford & Lipsedge, 2004). If the ancestors are angered, or if certain rituals and sacrifices are not performed, the ancestors may cause illness and misfortune for their living relatives (Edwards, 2011). Indeed, ancestors are known as “custodians of the lives of future generations” and must be respected as such, as they can bring both good luck or bad if they are pleased or angered (Edwards, 2011, p. 339). Because contemporary Zulu

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3 I completed my research in the province of KwaZulu-Natal, where Zulu is the most commonly spoken language at 77.8% of the population (Statistics South Africa, 2011).
4 This illness is particularly feared because the perpetrator does not have to be near his victim, and can even attack while the victim is asleep.
indigenous healing is based on the spiritual energy of the ancestors, most traditional healers, particularly sangomas, utilize their ability to communicate with the ancestors to help identify the illness, its cause, and its required treatment (Edwards, 2011).

Another crucial component of the Zulu conceptualization of illness deals with the idea of *ubuntu*. Although *ubuntu* is difficult to accurately translate, it can be defined as “humanity” or “beingness” and connotes a vast interconnected sense of community (Mpofu, 1994; cited by Edwards, 2011). *Ubuntu* implies that meaning in life is only possible through human relations and connections, illustrated by the Zulu phrase “umuntu umuntu ngababantu,” which translates to, “a person is a person through others” (Edwards, 2011). African culture is known to be ‘collectivist’ and ‘communalist’ because “it is kinship based, and the interests of the social group are more highly valued than those of the individual” (Yen & Wilbraham, 2003, p. 567). The same concept follows for theories of illness: both cause and treatment tend to revolve around social relationships and histories, and “[a] person is viewed as part of a family and larger community rather than as an isolated individual” (Crawford & Lipsedge, 2004, p. 133). Indeed, ideas of community and relationship are central to Zulu concepts of illness, a difference from the more individualized approach of Western psychiatry.

**Cross-Cultural Psychiatry**

Certainly, mental illness and traditional healing are both relevant topics in South Africa, and by extension, the relationship between them is important as well. It is known that culture shapes the experience and expression of mental illness and emotional distress (Kirmayer, et al., 2003). This is especially true for illnesses classified under the *ukufa kwabantu* classification; these illnesses are defined as being specific to African people and are therefore influenced by that specific African culture and set of indigenous knowledge. Thus, there is no way to treat such a disease without understanding these social and cultural influences. Misra and Gergen (1993) discuss this understanding:

This new orientation goes beyond the positivistic (Western) view of knowledge and proposes that the knowledge claims, particularly in the human domain, are relative to the cultural setting in which they are grounded. It is neither pertinent nor legitimate to claim culture-free generalizations (p. 239).
However, this becomes more complicated in regard to illnesses that appear to have a supernatural causation and also have similar symptoms to a Western-defined psychiatric illness. For example, the symptoms of *amafufunyana*, (evil spirit possession) have been classified as a sort of “hysterical psychosis” or schizophrenia, and the symptoms of *thwasa* (the illness indicating one’s calling to be a healer) are similar in nature to a kind of existential anxiety (Robertson & Kottler, 1983). In this way, one must ask: is a “cultural/spiritual problem” different from a “psychological problem” and if so, how?

It is also worth noting that traditional healers do not separate mental illness into a different category from other illnesses, as they believe that the mind, body, and soul are all intricately connected (Edwards, 2011). Indeed, for this reason, it is difficult to accurately know how traditional healers treat what the Western, biomedical world would consider a mental health disorder. For example, a study by Peltzer, Mngqundaniso and Petros (2006) found that mental illness was 14th on a list of most common conditions treated by traditional healers, affecting only 9% of their clients. However, conditions like ancestral problems (affecting 23% of their clients) and spirit illnesses (affecting 21%) are both ailments that, from a Western diagnostic perspective, could be characterized as mental illness, making the original figure much higher (Peltzer, Mngqundaniso, & Petros, 2006).

Indeed, by studying indigenous conceptualizations of mental illness, cross-cultural psychiatrists are, from the outset, defining their research from a Western perspective. Kahn and Kelly (2001) recognized this cultural bias in their study on the perspectives of Xhosa psychiatric nurses on traditional medicine: “Were we to consider how the mental health field is defined from within Xhosa culture, we would need to dispense with 'mental', and possibly also recast 'health’” (Kahn & Kelly, 2001, p.38). Kleinman also discusses this bias, explaining, “Most transcultural psychiatric research...is no more than the application of Western psychiatric categories to non-Western societies” (Kleinman, 1977). It cannot be overlooked that this is a major dilemma for most cross-cultural psychiatric research, this study included.
Methodologies

Sampling Plan

In total, I interviewed six traditional healers and four biomedical practitioners. Three of the traditional healers lived in a rural area outside of Pietermaritzburg and were recruited via convenience sampling by a gatekeeper within the community, who also happened to be my host mother.\(^5\) She also served as a translator during these interviews, all of which took place either at the healer’s home or regular place of practice. I utilized this gatekeeper/convenience sampling method because I was new to the community and was only there for a week; this method enabled me to speak with three healers in this short time. The other three traditional healers were also recruited using a gatekeeper, Nompumelelo Mbatha, a traditional healer and PhD student at the University of KwaZulu-Natal (UKZN).\(^6\) Ms. Mbatha connected me, via convenience sampling, with three healers, all of whom had previously come to UKZN for her project. I was able to interview them at the Traditional Healing Lab, using one of the PhD student’s research assistants as a translator.

I interviewed four biomedical practitioners in total: two occupational therapists, one psychiatrist, and one psychologist. They were contacted either via the website of their hospital, via the UKZN website, or via a snowball sampling process where an interviewee or SIT Lecturer would provide me with the contact information of a colleague. All interviews took place either in the practitioner’s personal office or in a public space such as a library or café. See Appendix I for more detailed demographic information of the participants sampled.

Data Collection Instruments and Methods

The data were collected through semi-structured interviews with traditional healers and biomedical practitioners. Additionally, based on the Short Explanatory Model Interview (SEMI), vignettes of various mental illnesses were presented to traditional healers in order to elicit a more specific and symptom-focused understanding of their perceptions of mental illness. SEMI is a

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\(^5\) The reason I refer to this area in general terms to maintain the privacy of my participants; more detail on this can be found in the ethics section.

\(^6\) For her PhD, Ms. Mbatha is working to meet with traditional healers from rural areas in the hopes of creating a formal training program and registration process of traditional healers. I was able to connect with her via snowball sampling (one of our SIT Lecturers, who works with her at the Traditional Healing Lab, gave me her contact information).
technique that was developed to understand the relation of culture to mental illness (Lloyd, et al., 1998). By presenting healers with vignettes of various mental disorders, this model attempts to elicit views on the nature of the problem, cause, and treatment of these disorders (Sorsdahl, Flisher, Wilson, & Stein, 2010). Although still problematic—because each vignette had a corresponding DSM-V diagnosis and thus was defined from a Western psychiatric perspective—using this model did enable me to better understand which disorders traditional healers would characterize under their perception of mental illness, as well as to gain insights into their ideas about causes and treatments for various psychological problems. The vignettes were written based on a combination of the DSM-V criteria for each disorder, my own personal knowledge from psychology and neuroscience classes, and the vignettes in Sorsdahl et al.’s 2010 study.

Key topics of the interviews with traditional healers included: knowledge and understanding of mental illness, causes and treatments of mental illness, and perspectives on collaboration with Western-trained practitioners. Key topics of the interviews with biomedical practitioners and experts included: perceptions of the mental health gap in South Africa, views on the abilities of traditional healers to deal with mental illness, perspectives on collaboration, and, if applicable, experiences with patients who utilized both disciplines (traditional and biomedical). Interview guides are provided in Appendix II. Interviews were recorded if the participant was comfortable; if not, handwritten notes were taken. Interviews were transcribed immediately following.

Data Analysis

The data gathered from traditional healers were broken down into sections: characterization of mental illness, cause and treatment of mental illness, and perspectives on collaboration with biomedical practitioners. The data collected from traditional healers on perceptions of four particular mental illnesses (depression, anxiety, schizophrenia, and bipolar) via the vignettes were broken down by classification of each illness, cause, and treatment plan as a way to better understand how traditional healers conceptualize mental illness. Data were transcribed, categorized and analyzed thematically. Responses to the vignettes were compared with traditional healers’ responses to semi-structured interview questions to gain insights into their

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7 Thematic analysis is a method for identifying, analyzing, and reporting patterns or themes within data, widely used in qualitative data analysis for its accessibility and flexibility (Braun & Clarke, 2006).
perceptions of mental illness as a more general concept, as opposed to its applications to more specific illnesses and situations. The data gathered from the biomedical practitioners were also transcribed, categorized, and analyzed thematically by sections, including but not limited to: gaps in the mental health system, perspectives on and knowledge of traditional healing, and opinions of collaboration with traditional healing systems.

In addition to primary source data from interviews, secondary sources were consulted to supplement my inquiry. I primarily used Google Scholar, Pubmed, Jstor, and CLIO (the online library through Columbia University). Keywords for these literature searches included but were not limited to: mental health; traditional healing; western medicine; collaboration; psychology; cross-cultural psychiatry; spirituality. Data from various sources, namely traditional healers, biomedical practitioners, vignettes, and secondary literature, were further analyzed using triangulation to achieve a more in-depth understanding of the phenomena and to enhance the validity of information collected.

Limitations and Biases

The major limitation of this study was the fact that interviews only took place over a span of three weeks—a time period containing four national holidays—making it difficult to interview as many participants as I intended. This was compounded by the fact that there were ethical issues with regard to conducting interviews within a healing space (such as a hospital or clinic), making me unable to access certain perspectives of biomedical practitioners who do not have a personal office space or whom I could not contact personally, such as psychiatric nurses. This made the range of my biomedical practitioners smaller, which is a major limitation.

Another limitation was that one of the traditional healers I interviewed (Participant 3) was a sangoma in training and had only been training for six months. Because of my limited access to traditional healers, I still interviewed him as a valuable perspective and included his responses in my findings and analysis; however, it should certainly be kept in mind that perhaps his responses are less “credible” as he has far fewer years of experience than all of the other healers I interviewed. A list of all participants, as well as their ages and number of years of experience, can be found in Appendix I.
An additional limitation was the language barrier when interviewing most of the traditional healers. Although a competent translator was used, each question had to be translated from English to Zulu, and then back to English, leaving room for error. Furthermore, certain phrases or explanations may have gotten “lost in translation” from one party to another, which likely limited some of the detail and depth of the responses received.

Finally, as already mentioned, this project is inherently biased. I, a white, American researcher, approached the issue from a Western psychiatric perspective, and so the project was biased from the moment I asked traditional healers about “mental health,” a culturally Western concept. Unfortunately, this is an issue for many cross-cultural psychiatric researchers. I attempted to mitigate the issue as much as possible by trying to ask culturally sensitive questions, utilizing SEMI, and acknowledging my partial perspective throughout my interview process and during my analysis of results.

**Ethics**

This project received ethical Local Review Board (LRB) approval (*Appendix V*). Before each interview, I explained my status as a university student and made it clear I was neither an expert nor a doctor and was not judging what participants told me in any way. I further explained that I did not want to steal any information but merely wanted to learn about the healers’ practices and experiences with mental illness. I made it clear that all participants would be anonymous unless they specified they wanted their name printed. I also explained that measures would be taken to maintain participants’ privacy and confidentiality, such as not referring to their specific location of practice by name, but instead through more general terms such as, “a rural area outside of Pietermaritzburg”. I asked each participant if he/she was comfortable with the interview being recorded on my phone; if so, I made sure to keep the recordings password protected and explained to each participant that I only used the recording to make sure I was quoting him or her correctly. I also kept my laptop—where I transcribed each interview—password protected, and kept my notebook either on my person or locked in my SIT locker. I did not interview any minors or vulnerable populations.

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8 For this reason, I refer (in both my notes and in this paper) to each participant by a different ‘Participant #’
The biggest possible stress to participants, in particular, the traditional healers, was the cultural divide that comes from me, the researcher, being a white, American outsider. Because I did not know the intricacies of their cultural and medical practices, perhaps I risked asking inappropriate questions. I took a few different measures to minimize this risk. First, I tried to research my topic very thoroughly and consulted with my advisor, an occupational therapist, on all interview questions and vignettes to ensure that they were as appropriate and sensitive as possible. Second, I made it clear to participants that they could refuse to answer any question I asked and could terminate participation in the project at any point. I also left my contact information so that participants could contact me at any time if they wanted to clarify, change, or revoke anything they said during our interview.

Finally, to minimize stress and bias, I employed, to the best of my abilities, the concept of bracketing: a social science technique in which researchers “recognize and set aside (but do not abandon) their a priori knowledge and assumptions with the analytic goal of attending to the participants’ accounts with an open mind” (Starks & Trinidad, 2007 cited in Tufford & Newman, 2010, p. 4). By doing so, I attempted to minimize any of my preconceptions and views that may have biased my results or stressed my participants.

I paid all translators a previously agreed upon fee, and I also paid the traditional healers their regular consultation fee. I did not provide any gift or compensation to the experts and doctors I interviewed, except for buying a tea or coffee if the interview took place at a café.
Findings: Overview

My findings are broken down into two sections: “Findings: Traditional Healers” and “Findings: Biomedical Practitioners.” First, I present the findings from traditional healers, including their responses to the semi-structured interview questions and their responses to the vignettes, and second, I present the findings from biomedical practitioners, which include only responses to the semi-structured interview questions. I then combine and analyze these findings in the analysis section.

Findings: Traditional Healers

General Definitions of Mental Illness

When first asked to describe what mental illness was, as well as how “mentally ill people usually act,” many of the traditional healers emphasized aggressive, violent, and disorganized behaviors; however, they also acknowledged that there was not just one description of how a mentally ill person would act, but that “there are many different ways” (Participant 2, 2017). Some healers explained how people who are mentally ill may display disorganized behaviors, such as “taking the things from here and putting them over there, when you talk to that person they reply with other answer”; “go[ing] out and run[ning] after the flies”; or “running away, picking up papers, want to take all the clothes off” (Participant 1, 2017; Participant 3, 2017; Participant 2, 2017). Four healers mentioned violent/aggressive behaviors as characterizing mental illness, such as becoming angry or “damaging things and biting” (Participant 10, 2017). One healer also noted that many people who are mentally ill are unable to live their lives as normal, stating, “Some of the people cannot perform their duties, cannot do things as usual” (Participant 9, 2017).

9 The vignettes were presented to the traditional healers in the hopes of gaining a greater understanding of their conceptualizations of various Western-defined psychiatric disorders; thus, the vignettes were not presented to the biomedical practitioners because of the fact that all of them were trained under a Western, biomedical framework, in which diagnoses of mental illnesses are more uniform and on which a wide range of literature has already been published.
Many healers also appeared to differentiate between mental illness and “stress.” This word came up frequently during my interviews, although its definition slightly differed from healer to healer. One healer explained the difference:

With the stress, it’s something that you think of it even if you try so hard to pass it, you can’t pass it. So there is a difference between mental illness and stress, with stress you always think of the thing even when you try so hard to forget about it but you can’t. And with mental illness, the illness comes and passes, and the other illness comes and passes (Participant 8, 2017).

Another healer explained that sometimes it is harder to tell, but that the spirits and ancestors help her differentiate between mental illness and “stress” (Participant 9, 2017). And although healers mentioned that mental illness can be treated with traditional medicine, two healers mentioned that “stress” requires not medicine, but counseling: “the only thing you can do for somebody who has stress is to talk to her…tell her to talk about the thing that worries him or her…advise her to go past that thing”; and “when you have stress, your family must come close to you, talk to you, then you’ll forget what you are thinking about, they just give you love” (Participant 8, 2017; Participant 2, 2017). Ideas about counseling recurred during the responses to vignettes and will be discussed in more detail in that section.

Perspectives on Treatment and Cause of Mental Illness

All six traditional healers said that they usually turned first to the ancestors to ascertain the cause of a mental illness. One healer explained how “you hear from the ancestors, then there’s some bones. Cha, throw them. He’s doing this or she’s doing this—why?” (Participant 10, 2017). Sometimes, the cause is directly from the ancestors themselves, especially if they are being ignored. One healer explained that mental illness could result when “Maybe like if they [the ancestors] want to talk to you and you don’t listen”; another explained, “when your ancestors are talking to you and you don’t do what they want you to do, they can make you mentally disturbed” (Participant 1, 2017; Participant 2, 2017). One healer explained that a person could become mentally ill when “the ancestors want you to work [as a sangoma]" (Participant 3, 2017). Another healer explained that mental illness could result if one denies or ignores this calling:

10 This process is called thwasa in isiZulu.
“People are scared to go training as a sangoma. They say it’s very hard, and that’s why they become mentally disturbed” (Participant 1, 2017).

Healers noted that other reasons for mental illness could involve failure to perform the proper rituals to honor the ancestors. One healer explained,

Usually these things have been caused by the people that have to do the rituals. Some of the children are born out of marriages in the wrong place, and they have to perform the rituals, but the parents are not there, sometimes the parents have passed away, and they discover these things very late, and people start getting sick. The only way to help that is to perform the rituals, then that person can be alright (Participant 9, 2017).

Another healer also noted failure to perform rituals as being one cause of mental illness but added three other causes: stress, accidents, and “bad behavior” (Participant 10, 2017). She went on to explain how “if you are stealing people’s things and they go for you, then you go mad” (Participant 10, 2017). Another healer also mentioned stealing, noting that mental illness can occur “if you do bad things to others, like you steal or do something, then people will turn that against you” (Participant 9, 2017). This experience, of people “turning against you,” was classified as bewitchment (Participant 1, 2017).

Ideas about treatment for the general concept of mental illness also varied, though many healers explained that they would use muthi to heal people of mental illness.11 One healer spoke of “a medicine that when you put in the nose, then you vomit, then after that for that person you can see there is a difference” (Participant 1, 2017). Another healer also mentioned putting muthi on the nose and using it to make a person drowsy, especially if he/she is violent or fighting (Participant 2, 2017). Other healers said that they would perform various rituals in order to help someone who is mentally ill, which can involve communicating with the ancestors, throwing bones, and burning imphepo.12 (Participant 8, 2017; Participant 9, 2017). One healer mentioned treating mental illness through what she called a “cleansing,” explaining, “you give the body cleansers, clean their whole system, because there’s something raw, an open wound somewhere inside” (Participant 10, 2017).

Opinions of Western Medicine

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11 Muthi is a term for traditional medicine in Southern Africa.
12 Imphepo means incense in isiZulu.
Many traditional healers noted that there were some illnesses that only a sangoma could cure, particularly bewitchment: “If you are bewitched, the doctors won’t help, it’s only the sangomas that can help” (Participant 2, 2017). Another healer also emphasized that doctors could not help when the ancestors call someone to become a sangoma, explaining,

The one when your ancestors want you to be a sangoma, sometimes when that happens it looks as if you are mentally ill. When you come to us and you have been to the doctors and they didn’t help you, when you come to us it is very easy when we are working with the spirits and we see that you need to become a sangoma, then we examine you, and perform our rituals as we used to do. Then you get better (Participant 8, 2017).

Healers also voiced some doubts about the medications that Western practitioners administer. One traditional healer acknowledged that the clinic dispenses “tablets” for people who are mentally ill, “but sometimes you don’t see any difference” (Participant 1, 2017). Two other healers explained that although the medication from the clinic does work, it must be taken for a longer period of time and does not heal people as quickly as a sangoma does: “On my opinion, the medication takes long. But the sangoma is fast”; and “When a person is mentally disturbed, then you give them that muthi until they are better, and it just stops there. But by the tablets you have to take them for your whole life” (Participant 3, 2017; Participant 2, 2017).

Some traditional healers acknowledged that there were certain illnesses they could not cure: “HIV, asthma, diabetes, high blood pressure, and TB…all those things you want to go to a doctor” (Participant 2, 2017). One healer also mentioned that congenital disorders would be harder for him to treat, explaining, “It can be when you were like this from birth, then that will be hard to the sangoma, but the doctors can help” (Participant 3, 2017). Another explained she could not cure mental problems caused by an accident, “like a car accident, or when they were in school the other boy hit my head. That one needs doctors. It’s not mine. Somewhere the blood doesn’t go through, you need the doctor” (Participant 10, 2017).

Some of the healers said that while they refer patients to the clinic or doctor, the doctor does not refer patients to them: “The clinics are not referring, so people usually start here, then the sangomas refer them to the clinics. Most of the time doctors are not referring to the sangomas” (Participant 3, 2017). However, many expressed that they would be willing to work with a doctor on a case, if such a system existed: “That would be very good, it’s just that we don’t have that opportunity. If we could get that opportunity, that would be great” (Participant 8, 2017). Another
healer explained that working with a doctor would give her the ability to more deeply understand people’s illnesses because the doctors have access to equipment that she does not:

I cannot give the person the drip, but the doctors can do. I cannot test blood, but the doctors can do. They can check the heart of the person, which I cannot do. Sometimes I know the person is suffering but I cannot exactly check. So it would be easier if we were working together (Participant 9, 2017).

Responses to Vignettes

Depression

A young mother comes to you because she has not been feeling herself lately. She recently lost her job and her boyfriend (the father of her new child) abandoned her unexpectedly. Since her boyfriend left and she lost her job, she worries about having money to support herself and her baby. She also tells you she does not eat much, sometimes stays in bed the whole day, and no longer enjoys the things she used to enjoy doing. She says she sometimes thinks of ending her own life.

Healers’ explanations for the causes of this woman’s situation varied widely. Two of the healers mentioned that perhaps the woman’s ancestors were calling her to be a sangoma but she was not answering (Participant 2, 2017; Participant 8, 2017). Another explanation for her problem included bewitchment, which “could be caused by the muthi that has been used by the other partners of her boyfriend” (Participant 8, 2017). One healer explained how “people can bewitch you…that’s what they call isichazo. When you have isichazo, you have that feeling that you must go and kill yourself…you don’t see yourself as a person” (Participant 1, 2017). However, another healer did not believe that the cause of the woman’s troubles had to do with the ancestors or bewitchment at all, but instead explained, “It is stress. She is alone now, and there is nobody to assist her to help her with the things that she needs, since she is no longer working” (Participant 9, 2017). Still, another healer remarked, “It can just be bad luck” (Participant 3, 2017).

Healers’ recommendations for treatment also differed. Three healers mentioned giving the woman traditional medicine and said that they would first consult with the ancestors to see what kind of medication to give (Participant 2, 2017; Participant 3, 2017; Participant 8, 2017). While some healers did not specify how the medicine would help, others said they would use it particularly “to bring back the boyfriend and look for another job”; or to “give her the medication so that when she goes out she can look bubbly and lovely…then when she’s looking for a job, she is able to find one. And she can get a man” (Participant 3, 2017; Participant 8, 2017). Four out of
six healers additionally mentioned talking/counseling as a possible way to help the woman in this vignette. One healer explained that she would first counsel the woman before giving her any traditional medication:

I will start by giving her trust, and giving her life, by counseling her, before I gave her any medication. And talk to her, and tell her that she can find another person, she can still have another person even if it’s not the father of the baby. Then after, I can start performing rituals or give her the medication (Participant 9, 2017).

Another healer also mentioned that she would counsel the woman first to ensure that she did not kill herself: “This person, she will end up taking a string, and talk to a tree, say help me, dead. So I must do counseling first” (Participant 10, 2017). When asked what they would do if this woman did not get better under their care, some healers explained that they would either switch the medicine they started with, or take the woman to a different sangoma who would be able to help (Participant 1, 2017; Participant 2, 2017; Participant 8, 2017). Another explained that she would take the woman “to the social worker for counseling” (Participant 9, 2017).

None of the six healers believed that this woman was suffering from a mental illness. One healer explained that because she could counsel the woman through her problems, the woman was not mentally ill: “She is not mentally disturbed, because I can give advice. That person has something that makes her mind think that much, it is not a mental illness. That person just needs advice because of stress and a lot of thinking” (Participant 2, 2017). Another healer also explained that because the woman was aware of what was going on in her life, she was not mentally ill, but instead had stress:

Because she came to me and told me what is happening with her life, and she told me she was going to kill herself, surely that person knows what is happening. So she doesn’t have mental illness, she has a stress, because people with mental illness, usually they don’t know what they are doing, they could even strip themselves and go around not knowing that they are naked. So with her, she just explained everything to me, so it’s obvious that she has a stress (Participant 9, 2017).

This explanation offers another helpful comparison between mental illness and stress, essentially explaining that mentally ill people are unaware of what is happening to them, while people with stress are aware of their problems and thus can be counseled through them. Yet another healer explained that this woman was suffering because she was troubled by what was going on in her
life, and was not because she was mentally ill: “She is not suffering from mental illness, she is suffering from this breakup of the relationship, and the loss of the job” (Participant 8, 2017).

Anxiety

A middle-aged man comes to you explaining he is afraid of going to places where there are many people. A few months ago when he was in town, he got mugged by a group of boys and they took all his money on payday. He used to work in town but now does not go to work and is worried about having enough money for rent and food. He used to love going to soccer games but now he does not like them because when he is in large crowds, his heart begins to beat very fast, he starts sweating, and he feels like something bad is going to happen. He rarely leaves his house anymore and has trouble sleeping at night.

The healers had a variety of responses as to what caused this man’s problem—some said it was the ancestors trying to speak with him, others mentioned stress, and still others mentioned bad luck and carelessness (Participant 1, 2017; Participant 2, 2017; Participant 8, 2017; Participant 9, 2017). However, four of six healers said that they would begin by simply talking with the man about what had happened to him. One healer explained, “In that person there’s no medicine, you have to talk to that person and advise him, it’s not the end of the world, if something happens to you once that doesn’t mean that every time you will be mugged. Just talk to him, give him advice and that person can be fine by that” (Participant 2, 2017). Another healer echoed this idea, explaining how she would logically talk the man through his worries and encourage him to move on with his life: “You could tell him that those people, they don’t stay there, from where he was mugged. They are no longer there, they are gone. The life goes on, he has to go back to work and everything” (Participant 9, 2017). Other healers mentioned practical ways of helping the man, such as “advise him to go to the police station so that he can get help” or “you can use traditional medicine so that the people that stole that money will bring that money back” (Participant 8, 2017; Participant 3, 2017).

Responses also varied widely as to what the healers would do if the man did not get better, though some did mention referral to a Western practitioner. Two healers said that they would send this man to the social worker for help (Participant 8, 2017; Participant 9, 2017). Another healer mentioned that she would refer this man to the doctor “to get some injections to heal the nerves. Because he’s nervous, so there’s a referral there” (Participant 10, 2017). Yet another healer disagreed, explaining that in this situation, “at the clinic they won’t help” (Participant 1, 2017).
The other two healers said they would refer this man to another sangoma if he were still not well (Participant 2, 2017; Participant 3, 2017).

All six healers agreed that this man was not suffering from a mental illness. Many of them cited the fact that because something happened to the man, which caused him to become this way, he was not mentally ill: “No you can’t put that person to be mentally disturbed, because something happened to him, that’s why, that’s the cause”; and “Not a mental illness, you are just afraid of that time because something happened to him” (Participant 3, 2017; Participant 2, 2017). Another healer again mentioned that the man’s awareness of his problem meant it was not a mental illness: “He knows what happened to him, so he is not mentally ill” (Participant 9, 2017). Interestingly, unlike the depression vignette, none of the healers mentioned the word “stress” when discussing the reason for this man’s problems.

**Schizophrenia**

A young man is brought to you by his family because he has been acting strangely. He is often found alone, talking to himself. He says that he hears voices in his head telling him to do things, and has visions of people following him to check what he is doing. He has stopped going to work, rarely takes a bath/washes and mostly stays inside the house. He does not talk to anyone and does not even answer the door when neighbors come by.

Five of six traditional healers said that the ancestors were likely behind the cause of this man’s problem, either because they were calling him to become a traditional healer, or telling him to perform certain rituals. One healer put it bluntly: “It is so obvious. He has been attacked by the ancestors. That means he needs help from me” (Participant 8, 2017). Another healer explained that when the ancestors speak to you, it can sound like voices in your head, especially for someone who is not yet a trained sangoma: “It is just the ancestors that are talking, because most of the time, when they are talking to you, you hear like someone is talking to you, you hear it in your head. But if you are not trained you won’t understand what is going on” (Participant 1, 2017). Another agreed, explaining how “the ancestors do that, hearing voices, feeling like someone is following you. That’s if the ancestors want you to work as a sangoma, tells you to go to training” (Participant 3, 2017). The only healer who did not mention the ancestors as being involved in this problem said that instead, the man “needs the cleansing to cleanse the body. Not the rituals. You give the body cleansers, clean their whole system, there’s something raw, an open wound somewhere inside” (Participant 10, 2017). Interestingly, other than this healer, none of the healers
mentioned an exact treatment plan for this man, but instead just explained that the ancestors would tell them what to do for him; the treatment plan would depend upon whether he was being called to be a healer, was bewitched, or otherwise.

Five of six healers said that if this man did not get well, they would send him to another traditional healer; the sixth said that while she would first send him to the doctor, the man would then need to come back to her to get her treatment as well: “I would send to the doctors, to get one or two injections so he will sleep...then he comes to me, I wait maybe for three days, then I start” (Participant 10, 2017). The other healers either did not mention the doctor/clinic at all, or were vehemently opposed to sending this man there, explaining “I would not take that person to the clinic, because those things, something that the people are hearing, that thing needs to be done my muthi, not by the clinic”; and “I would send him to another sangoma because I know what troubles him, I would never take him to a doctor” (Participant 2, 2017; Participant 8, 2017).

The healers were also divided over whether this man was suffering from a mental illness. Four of the healers did not think the man was mentally ill, though one acknowledged, “that still means he’s got a problem that must be checked” (Participant 2, 2017). The other two healers agreed that the man had a mental illness (Participant 3, 2017; Participant 9, 2017).

**Bipolar**

_A young woman is brought to you by her parents who are very worried about her. They say that last week she had an abnormal amount of energy: she barely slept and instead she stayed up very late cooking a lot of food, doing loads of washing, and cleaning the whole house. She says she has “many thoughts coming into her head,” she was talking very quickly without stopping and laughing for no reason. However, this week she has barely gotten out of bed, she is very quiet and sometimes cries for hours at a time. She refused to go to a family party and slept all day instead._

Although some healers admitted they did not know the cause of this problem and would have to consult with the ancestors to check what was wrong, others were believed that this woman was experiencing _thwasa_ and needed to go into training to be a sangoma. Some healers emphasized the fact that the woman was alone and isolating herself, explaining, “if you hear these things that means someone is talking to you so that you have to be there alone, listening to that person”; and “others they cry and go away, some of their members of their family, they follow them, only to be found out that she’s been led by the ancestors to this place, or to a sangoma that has to perform these things for becoming sangoma” (Participant 1, 2017; Participant 8, 2017).
Others did not know the cause but did acknowledge that the woman’s symptoms were strange, and so a consultation with the ancestors was needed: “You won’t do all those things without anything, when you are laughing you can’t just laugh alone. Go first to the ancestors to communicate and check what’s going on” (Participant 2, 2017).

One healer believed that this woman needed counseling, and explained that sometimes it is important just to sit, listen, and tell stories:

She also needs counseling. She needs someone who’s got a lot of love, then the story is gonna come—why? Talk to her. Even when you want to hear her story, tell her your own stories. Tell the stories, but you want her story. But you tell your stories, then you say, oh, me too. Then after that, ay man, you can’t die from that. Look at people, they’re alright. You make her trust you, so she can see that she’s not alone. For counseling, you must be trustworthy, she’s telling you this and it stays here (Participant 10, 2017).

Another healer agreed that counseling could be necessary, and explained that she would “send that person to the clinic so they can be checked by a psychologist because maybe there’s something wrong in her mind that needs a psychologist” (Participant 2, 2017). Still other healers were firm in their belief that this woman was experiencing signs from the ancestors, and stressed that they would not send her to the clinic, but instead to another sangoma if they could not help (Participant 8, 2017; Participant 9, 2017).

Two healers agreed that this woman’s experience “can be the beginning of mentally disturbed,” but many of the others did not think she was suffering from a mental illness and instead “she has to perform the sangoma duties” (Participant 2, 2017; Participant 8, 2017). One healer purported that perhaps something was going on in the woman’s life to make these things happen to her, and because those things caused the woman to act this way, she was not mentally ill: “It’s like she was trying to get rid of something, there was something that was following her mind” and for this reason “it is not a mental illness, it’s because of something” (Participant 10, 2017).

**Findings: Biomedical Practitioners**

*Gaps in the South African Mental Health System*

All four biomedical practitioners interviewed noted gaps in the mental health system in South Africa, particularly due to lack of funding and unequal distribution of resources. Two participants stated that because of the problems South Africa is currently facing with
communicable diseases—particularly HIV and TB—mental health is neglected, and “the budget tends to favor the life-saving type of interventions compared to mental illness” (Participant 4, 2017). This may be compounded by the fact that there is still a stigma around mental illness in South Africa in that sometimes it is not readily accepted as being a medical condition (Participant 6, 2017). All four participants also mentioned a lack of human resources, particularly in rural areas, as being an issue for mental health delivery: “There are so many people and the facilities are so limited…the government has gone a long way in building more facilities, but that has not been synchronized with the production of human resources” (Participant 4, 2017). Indeed, it was noted that especially for mental health, there is a lack of specialized medical personnel: “Most of the district hospitals, which are mostly in the periphery of the cities, they don’t have psychiatrists. Some don’t even have a psychologist…or you find that the psychologist only comes once a month, and the clients can’t wait for that long because their problem is immediate” (Participant 5, 2017). In these types of cases—where specialized psychiatric care is vitally needed—patients are usually referred to a larger tertiary hospital, but this is problematic in rural areas where the nearest hospital with a psychiatric ward may be far away (Participant 6, 2017). For this reason, it was noted that many people tend to give up and look for alternative treatment, particularly from traditional healers (Participant 4, 2017; Participant 7; 2017).

*TTraditional Healers: First Port of Call*

Three participants mentioned that many people begin their medical process by consulting a traditional healer (Participant 4, 2017; Participant 5, 2017; Participant 6; 2017). One participant explained, “Traditional healers are so much more in number…we probably have a couple of hundred psychiatrists in all of South Africa, and with traditional healers, you’re looking at close to 200,000. So they’re far more accessible to patients, and often patients will go there as their first port of call” (Participant 6, 2017). Certainly, in some cases, this first attempt with a traditional healer is successful, and the process ends there. However, for others, it was noted that a cycle can begin in which a patient first consults a traditional healer, does not get better so then goes to the clinic or doctor, but then afterwards goes back to the healer: “It becomes a cycle like that—until the family gets to a point where they say, there’s nothing more we can do. Then they start to believe and rely on the Westernized approach. But first they must go through that cycle of trying” (Participant 5, 2017).
Traditional vs. Western Healing of Mental Illness

Participants had mixed feelings about traditional healers’ ability to treat mental illness, but all acknowledged that traditional healers could provide some benefit in particular situations. One participant explained that because traditional healers understand a patient’s culture and background, they are sometimes better equipped to provide care: “I think traditional healers do very well in terms of a support system, and understanding the tradition, and interpreting what they hear. Western doctors, on the other hand, tend to misunderstand the explanation which has a risk of misdiagnosis” (Participant 4, 2017). Another explained that traditional healers do a good job of interpreting the problem, and providing an explanation for its cause while a doctor may not:

People believe, oh, maybe I am bewitched by somebody or something, that’s when people interpret that way that doctors can’t see. And mostly when the doctors say, we can’t find what is wrong with you, what comes first into the minds of most of the African people, is that I need to go to the traditional healer, then they will know what is happening. And then they go there, and it gets interpreted there (Participant 5, 2017).

Another participant also acknowledged that sometimes, Western practitioners are unable to provide an explanation for illness that is culturally congruent to whatever the person believes in:

A lot of the time a failure of the Western paradigm of mental illness is it doesn’t give an explanation as to why, within your frame of mind. Not everybody can understand the concept of brains, and chemicals. And also because mental illness is multifactorial in its etiology, so you have to look at the biology and psychology and social factors, etc. We have failed in that aspect in terms of a providing a plausible, meaningful explanation to patients. So I don’t think it’s fair to decline them their own belief systems if it makes sense within their worldview (Participant 6, 2017).

Other participants also brought up the point that traditional healers are able to assign a meaningful explanation and cause to various mental illnesses. One participant mentioned that a negative aspect of the Western mental health system is its failure to acknowledge the cause of illness, whereas traditional healers will always look to the reason or cause for the problem: “The psychiatrist often just gives a medication and you come right, but actually there’s always a cause…and the sangomas will ask the whole background, already know it, or will divine it by throwing bones” (Participant 7, 2017).

Still, other participants acknowledged that while “there are some aspects that can be handled by traditional healers, these are linked loosely to the traditional belief systems. It’s more
of a belief than an actual intervention” (Participant 4, 2017). Another explained that many times, traditional healers only utilize their traditional belief systems and do not look for other causes of illness, “The unfortunate part is that every case that comes to them, they’re gonna throw the bones and they will say it’s the ancestors’ issue. That’s usually where I say the imbalance lies” (Participant 5, 2017).

**Biomedical and Traditional Healing in Tandem**

Participants noted that although many people stick to one system or the other (biomedical practitioners or traditional healers) others attempt to straddle the two disciplines. One participant told of a patient whose condition improved after being in a chronic institution and taking medication, but who then went home and called her traditional healer to perform a slaughtering ritual, a clear example of “someone whose condition has been managed through the Western system, when she gets better they still don’t believe that it’s because of the drugs, they still believe it’s because of the ancestral powers that she got well” (Participant 4, 2017). Another participant also explained that “it is not uncommon for patients to take the psychiatric medication but also to see a traditional healer who will tell them what they need to do to right a wrong from the spiritual perspective, and so a lot of patients have a dual kind of relationship with that” (Participant 6, 2017).

While in certain cases, this dual relationship can work well, all four practitioners noted that in others, it can be detrimental to the patient’s health and wellbeing. Many people who are mentally ill are in a particularly vulnerable state, and so are at higher risk of being exploited both financially and in terms of care by people who are not bonified traditional healers (Participant 6, 2017). Indeed, because traditional healers are not formally regulated, there can be “fake” traditional healers who are “just out there to make money out of people, they don’t know anything, they don’t know what they are doing” (Participant 5, 2017). This lack of regulation and education can also pose problems when traditional healers prescribe certain medications. Although not as common with mental illness, it was noted that sometimes patients who are HIV positive and consult traditional healers can become very sick after taking *muthi* because it can react with their ARVs (Participant 7, 2017). This was also mentioned as being a risk for TB patients who are
treated by traditional healers—either the medicines react with other drugs or do not work at all (Participant 5, 2017).

**Working Together with Traditional Healers**

Many of the biomedical practitioners expressed an interest in working with traditional healers, but explained that it would be important for the healers to be formally registered first: “They must be registered, they must belong to a certain body, so that there’s a little bit of regulation of what they do, and we are able to give them more information as well” (Participant 5, 2017). Three of the practitioners mentioned that registered traditional healers could be a vital part of a patient’s multidisciplinary treatment team; one practitioner described how “we are inclusive, we have psychologists, social workers, occupational therapists, other medical people as well, so why not traditional healers?” (Participant 6, 2017). Another practitioner, who was an occupational therapist, explained, “There must be a link between the two, open communication. Just like I as an occupational therapist talk to the doctor, I talk to the psychologist, to the psychiatrist, and suggest what they must focus on, they tell me what they suggest I must focus on, I think that kind of relationship could work [with traditional healers]” (Participant 5, 2017).

Another participant mentioned that traditional healers could potentially play a big role in health promotion, because “they have huge numbers, and if we could harness that then we could do a lot with health promotion” (Participant 6, 2017). This participant went on later to describe more about the potentials for integration with traditional healers:

One of the things that we just haven’t gotten around to implementing is to work collaboratively with them as partners. Because I think we are quite clear about our respective scopes of practice, but if we can cross-referral and work together as a team I think we’ll do much more for our patients, where they can reinforce some of the advice that we give patients, and in turn we can rely on them to help to screen and refer appropriately, but also to promote healthy lifestyles. I think perhaps patients would be more receptive to the advice coming from somebody within their own cultural belief system than from us. So I think it can be a win-win situation if it is properly implemented, which currently it isn’t (Participant 6, 2017).

Other participants agreed, stressing that an open dialogue was essential to working together. One participant explained that “it’s just a matter of these two parties talking and getting more avenues to work collaboratively”; another stated that it is important “to really be open to it and say to your African patients, you’ve got this diagnosis in my Western frame, I’d be very happy if you also felt..."
a need to go to your sangoma and you told me about it so we can see, how are we going to cure this. And just encouraging the openness” (Participant 4, 2017; Participant 7, 2017).

Analysis

*Traditional Healers’ Conceptualizations of Mental Illness*

From their responses to general questions about mental illness as well as from their responses to vignettes, it seems that the traditional healers more frequently identified psychotic disorders (in this case, bipolar and schizophrenia) as falling under the characterization of mental illness, while non-psychotic disorders (in this case, anxiety and depression) were not considered to be mental illnesses. None of the healers agreed that the people in the anxiety and depression vignettes were suffering from a mental illness; however, two healers believed that the man in the schizophrenia vignette was suffering from mental illness, and two healers believed that the woman from the bipolar vignette was suffering from mental illness. Not only that, but in their initial general descriptions of someone who was mentally ill, most healers mentioned characteristics of psychotic disorders, such as disorganized behavior, hallucinations/delusions, and aggressive/violent behavior. This result is similar to that of Sorsdahl et al.’s 2010 study, “Explanatory models of mental disorders and treatment practices among traditional healers in Mpumulanga, South Africa.” In this study, vignettes of psychotic and non-psychotic disorders were presented to traditional healers via 4 focus group discussions and 18 in-depth interviews; the researchers found that psychotic disorders were the main exemplars of mental illness, while non-psychotic disorders were not seen as mental illnesses at all (Sorsdahl et al, 2010). In the present study, the result was not extreme by any means—only four healers total characterized any of the disorders presented in vignettes as being exemplars of mental illness—but is worth noting all the same.

Despite the fact that traditional healers did not define non-psychotic disorders as being mental illnesses, they still suggested various treatments that could be effective. Some of these
suggestions included practical solutions to the problems presented, many of which took into account the context of the situation and community: in the depression vignette, many healers mentioned that they would help the woman get her job back, assist her in caring for her child, or help her find a new person to love; in the anxiety vignette, healers suggested that they would advise the man to go to the police to report the incident, or use traditional medicine to help the man get his money back from the people that stole it originally. Crawford and Lipsedge (2004) explain that for many traditional healers, the social origins of illness are crucial: “the Zulu tradition locates both the source of individual psychological distress and responsibility of its treatment firmly within the community” (Crawford and Lipsedge, 2004, p. 143). One healer mentioned, in response to the anxiety vignette, the importance of family and community as well: “Your family must come close to you, talk to you, then you’ll forget what you are thinking about, they just give you love” (Participant 2, 2017). These practical solutions aimed to take the psychosocial context into account while also viewing the person in question as a part of the larger community, not as an isolated individual; one of the biomedical practitioners recognized this as well, explaining, “the other aspect of it [traditional healing] is quite supportive, because in their approach they look at the family, the households, rather than an individual. When someone is sick in a traditional sense, it is because the ancestors are angry, and the whole family must undergo a cleansing or treatment, rather than the individual” (Participant 4, 2017).

Additionally, many healers brought up the idea of counseling, usually in relation to non-psychotic disorders but also sometimes for psychotic disorders. One healer recognized that some problems did not require rituals or medicine: “If it’s on the nerves, because I lost all my children, my mother, my father, I’ve got no food, I’ve got no money, I’ve got no work...that one needs counseling. That one needs counseling, not even medicine (Participant 10, 2017). Another healer also explained that sometimes medication was not necessary; in response to the anxiety vignette, she explained, “In that person there’s no medicine, you have to talk to that person and advise him, it’s not the end of the world, if something happens to you once that doesn’t mean that every time you will be mugged” (Participant 2, 2017). Yet another healer, in response to the depression vignette, explained, “I will start by giving her trust, and giving her life, by counseling her, before I gave her any medication” (Participant 9, 2017). In this way, traditional healers seem to play the role of a counselor within the community, acting as a source of love, trust, and “life” for people experiencing illness or trauma. This result is also congruent with the findings from Sorsdahl et
al.’s 2010 study, in which many healers reported emphasizing counseling as an option, especially for patients suffering from non-psychotic disorders (Sorsdahl et al, 2010).

Another way that traditional healers appeared to classify mental illness was by the degree of awareness a person had of their problem. One healer explained that the woman in the depression vignette was “not mentally disturbed, because I can give advice…that person just needs advice because of stress and a lot of thinking” (Participant 2, 2017). Another healer, in response to the depression vignette, explained,

Because she came to me and told me what is happening with her life, and she told me she was going to kill herself, surely that person knows what is happening. So she doesn’t have mental illness, she has a stress, because people with mental illness, usually they don’t know what they are doing, they could even strip themselves and go around not knowing that they are naked. So with her, she just explained everything to me, so it’s obvious that she has a stress (Participant 9, 2017).

This description again fits with the observation that psychotic disorders are more likely to be classified by traditional healers as a mental illness because a main feature of psychosis is a loss of touch with reality, whereas people with non-psychotic disorders tend to have a higher degree of awareness of their problem (National Alliance on Mental Illness, 2017).

All traditional healers mentioned the ancestors as being central to their diagnostic system in some capacity, as well as to the underlying cause of many psychological problems. It was frequently reported that when someone presents to a healer with a problem, the first order of business is to consult with the ancestors: “You hear from the ancestors, then there’s some bones. *Cha*, throw them. He’s doing this or she’s doing this—why?” (Participant 10, 2017). Another participant explained, “I’ll start by looking at what was the cause of all these things? I will start by examining him, then performing the spiritual things and check on what was the cause of this. It can be the ancestors, they want something from him, it can be that they need the rituals, I don’t know, but I’ll find out when I just examine him” (Participant 9, 2017). Indeed, not only do the ancestors provide answers as to why a certain illness or problem is occurring, but they themselves can sometimes be the root cause of illness if they “want something” from someone.

*Cultural/Spiritual Problems* vs. *Psychiatric Problems*

One of the central questions in this study aimed to explore the distinction (if there is one) between ‘cultural/spiritual’ problems and ‘psychiatric’ problems. One instance where this idea
became relevant was in the responses to the schizophrenia vignette, as many healers interpreted it as being either bewitchment or *thwasa*, the calling to become a sangoma. Indeed, the symptoms of *thwasa* are similar to the symptoms of schizophrenia: hearing voices in one’s head, talking to oneself, isolation, and the potential for disorganized behavior or madness, especially if the call is ignored (Robertson & Kottler, 1983). However, none of the traditional healers interviewed said they would ever refer someone suffering from *thwasa* to a doctor or clinic; this was strictly a problem for the sangomas, and a Western-trained practitioner would be unable to help.

This indicates that there may be certain psychological problems that fall under the realm of “spiritual illnesses”, classification of which is mainly dependent on the cause of and explanation for illness. One finding from Kahn and Kelly’s 2001 study—in which they surveyed 77 Xhosa-speaking psychiatric nurses about their perspectives on traditional healing of mental illness—was that while many of the nurses would refer a patient to a traditional healer if he presented with *thwasa* (calling to be a healer), or *amafufunyana* (spirit possession), they were less likely to refer him to a traditional healer if he presented with schizophrenia or drug abuse (Kahn and Kelly, 2001). Indeed, this is not limited to *thwasa*: it appeared that in general, whenever the ancestors or spirits were brought up as being a perceived a cause of illness, most healers said they would refer the patient to another sangoma if he did not get well, but not to the clinic or to a doctor.\(^\text{13}\) Many of the biomedical practitioners in this study agreed that traditional healers are better equipped to treat certain types of culturally or spiritually-bound illnesses than Western-trained practitioners:

“Sometimes I would say they [traditional healers] are correct, they are spot on, because we do see clients then they come back and they are OK after they went to the traditional healer. So there is that spiritual aspect, that they can contribute in it” (Participant 5, 2017). This practitioner also acknowledged, however, that sometimes it is unclear when an illness is spiritual or not, explaining, “I would say that the difficult part is to draw a line, as to where a psychiatric problem

\(^{13}\) It is worth noting the converse as well: when cultural factors are the apparent cause of a psychological problem, but the patient ends up at a hospital or clinic, there can be a potential for misdiagnosis. A 1981 study conducted at King Edward VIII hospital in Durban found a disproportionally high rate of schizophrenia diagnoses reported for Xhosa, Zulu, and Indian patients who had been referred to the hospital; additionally, many of the diagnoses were inaccurate. The researchers posited that this was in part due to a misinterpretation of cultural phenomena (Cheetham & Griffiths, 1981).
is really related to the ancestors, or a curse or spiritual thing, or if it’s just a typical mechanical imbalance” (Participant 5, 2017).

Some traditional healers do appear to be able to draw that line. One healer said that although she would not refer someone to a doctor if he was undergoing thwasa, she would refer him to a doctor if he had psychological problems that developed from an accident or trauma: “So what I can’t cure, and that one needs a doctor, it’s when the child was small, he fell of the tree, and he hit his head. That was a damage somewhere…you go to the hospital and get scanned, and they found oh, this nerve is broken” (Participant 10, 2017). Another healer agreed that certain naturally-occurring illnesses might require referral to the doctor: “When you were like this from birth, then that will be hard to the sangoma, but the doctors can help” (Participant 3, 2017). This echoes the umkhuhlane vs. ukufa kwabantu distinction discussed by Ngubane (1977), in which healers can distinguish between umkhuhlane, naturally occurring illnesses, and ukufa kwabantu, illnesses that are more psycho-cultural-spiritual in origin (cited by Edwards, 2011).

Another relevant aspect, however, is that the two do not necessarily exist in isolation. Interestingly, one of the biomedical practitioners explained that she has had patients who are traditional healers, but also experience psychotic delusions, and can tell the difference between the two:

I have treated patients like that, and so they come and they will tell you, listen, when I am the sangoma, when I am communicating with the ancestors, this is what I hear, this is what the experience is like, but when I’m ill, mentally ill, this is what the voices say, this is how I behave, which is different. And once we treated her we asked, can you still hear the other voices, the ancestors? And she said yes that’s still there, but the other voices have stopped. So that’s a very clear way of making that distinction (Participant 6, 2017).

From this example, it seems that not only are spiritual problems different from psychiatric problems, but that more importantly that “the two can coexist” (Participant 6, 2017). This idea—the coexistence of biological and spiritual illnesses—speaks again to the idea that formal collaboration should be established between traditional healers and biomedical practitioners, because they can each provide unique services that are stronger when used in tandem. For instance, in response to the anxiety vignette, one healer explained that when the problem is serious, sometimes she would refer someone to the doctor to temporarily “stop the thing for a while” and “hold it” but then she must treat him afterward to “get it out for good”:
You see, when it’s serious the doctors stop the thing for a while. It stops for a while, then I come and sweep it out. I come first, and then I refer, and then they come back. Go to the doctor, because that injection will hold it, it doesn’t take it out. While it is on that holding time, then I can get it out for good (Participant 10, 2017).

In this way, it seems that a dual-system relationship between traditional and biomedical practitioners would be most effective, where one group treats the more biomedical aspects of a sickness, and the other treats the more spiritual side—because for many people, “culture does considerably more than shape illness as an experience, it shapes the very way [they] conceive of illness” (Kleinman, 1977, p. 4).

Possibilities for Collaboration

Both groups—biomedical and traditional—acknowledged that there are certain mental problems that are beyond the scope of their respective abilities and which require consultation with the other discipline. However, both sides also recognized that there are not yet specific avenues for this collaborative process to occur. One of the biomedical practitioners interviewed, a psychologist, expressed that though she believed certain psychological problems that are spiritual in nature should be covered by traditional healers, she has never actually referred a patient to a traditional healer: “I have been encouraged to refer my patients to traditional healers, but I never have actually connected up to them” (Participant 7, 2017). She went on to remark, “But often I think they’ve gone anyway” (Participant 7, 2017). Another participant acknowledged that while some strides had been made to work with traditional healers with respect to HIV, the same gains have not yet been made for mental health: “In terms of HIV, I would say South Africa has made big progress, because in HIV there’s always meeting with traditional healers, and there’s an association. We’re even assisting them in terms of making sure they don’t contract the disease. But with mental health I have no clue how far that has gone” (Participant 5, 2017).

Yet another biomedical practitioner made the point that not only is collaboration with traditional healers necessary, but also that changes should be made to the Western “syllabus” of medical training to include culturally sensitive and culturally relevant ways of treating patients: “We have to understand the scope of each other’s training and expertise—in that way then there would be comprehensive interventions for this client. The way to go would be to review the syllabus so that it is integrated into all the systems. At the moment, it doesn’t help to work in isolation” (Participant 4, 2017). Another biomedical practitioner also mentioned this idea in
reference to the current push—in South African universities but also in universities throughout Africa—to decolonize the education system and to take specific cultural contexts into account:

In South Africa at the moment there is a big dialogue for decolonizing the education system, which is one of the things I believe in as well. Some of the solutions that we tried to apply in our context, they’re not working. Because they were not thought through for our context. So we do need to twist that a little bit. You know, coming with systems that considers our context, that considers the area we live in, how things are happening, how things are done, and all that (Participant 5, 2017).

As already mentioned, traditional healers also seemed interested in collaboration with biomedical practitioners, explaining, “That would be great, because I cannot give the person the drip, but the doctors can do. I cannot test blood, but the doctors can do…so it would be easier if we were working together” but also recognized that “it’s just that we don’t have that opportunity. If we could get that opportunity, that would be great” (Participant 9, 2017; Participant 8, 2017). It appears that while both sides—traditional and biomedical—are interested in collaboration, the avenues through which to do so, at least for mental health, are not yet well established.
Conclusions and Personal Reflection

First, it is important to bear in mind that this was a small study and its results cannot be generalized to all traditional healers or all biomedical mental health practitioners in KwaZulu-Natal, let alone in all of South Africa. However, despite the limited sample size and limited time frame, the findings do show that for many reasons, there is a need for increased communication and dialogue between the worlds of traditional healing and biomedicine in the treatment of mental illness.

It appears that many of the traditional healers in this study do have some understanding of mental illness as defined by a Western psychiatric framework; however, they tend to characterize psychotic illnesses as being more exemplary of mental illness than non-psychotic illnesses. Some psychological problems were interpreted as being spiritual in nature, resulting from ancestral problems or callings, issues with performing certain rituals, or bewitchment; various other psychological problems were interpreted as “stress” resulting from life events or external stressors and were treated via counseling or with muthi. Traditional healers also had an understanding that there were some mental illnesses they could not cure, which required referral to a Western medical system.

The biomedical practitioners recognized the importance of traditional healing, especially within the South African context, and explained that there were certain “spiritual illnesses” that a traditional healer would be better equipped to deal with than they. However, they also noted that sometimes, traditional healers do not treat mental illness properly, resulting in the patient getting sicker and ending up in a hospital or clinic, anyway. It seems that generally, the cause of and explanation for illness are crucial parts of understanding which system—traditional or biomedical—should handle the problem, as well as what treatment should be offered.

Indeed, both biomedical practitioners and traditional healers recognized that while there are certain psychological problems they can adequately treat, others might require consultation with the other system. For this reason, many of the participants believed that the systems must become more integrated, which would create increased communication and open a dialogue between the two. In this way, the traditional healer and the biomedical practitioner could become partners in a patient’s multidisciplinary team, each providing unique but important aspects of care. If this happened, biomedical practitioners would become more educated on cultural and spiritual causes of illness, and traditional healers would become more educated about chemical and
biological causes of illness. Indeed, both sides are crucial, especially in the South African context where the spiritual and cultural parts of a person so often influence their perceptions and understanding of sickness. These aspects cannot and will not be abandoned; instead, they must be taken into account as equally vital parts of that person and utilized in that person’s treatment as such.

On a personal note, this project has deeply impacted me. I want to become a doctor one day—potentially a psychiatrist—and although I will likely be practicing medicine in a very different context than that of South Africa, I will certainly be confronted with patients whose belief systems are different from mine, and whose belief systems can and will impact the way they view their illness. I now know more than ever that I cannot dismiss these belief systems but instead I must accept and attempt to understand them in the hopes of integrating them into the way I care for my patients. I must also recognize that there are things I cannot fully understand, and that it is OK, necessary even, to ask for help from someone who does. One of the traditional healers put it well: “What I know, I know. What I don’t know, I don’t know. I don’t know everything. If I don’t know, I’ll call someone else” (Participant 10, 2017). Indeed, I never want to become the stereotypical doctor who can never accept she is wrong, who whisks quickly in and out of the room, 15 minutes for each patient, sterile white coat around her shoulders and iPad in hand; the doctor who is all brains and no heart, who does not have time to learn her patients’ language, who does not listen carefully to their personal histories, backgrounds, and fears. Just as in the case of Lia, the epileptic Hmong child, “Every illness is not a set of pathologies, but a personal story” (Fadiman, 1999, p. 277). Indeed it is crucial, as both a physician and as a human being, to listen to these personal stories and use them to understand patients as more than a sum total of their biological parts, but instead as the whole, complex, unique beings that they are.
Recommendations for Further Study

As previously mentioned, this project was limited in scope and time. Because of this, my first recommendation for further study would be to expand the sample size of both traditional healers and biomedical practitioners. Additionally, a wider range of types of biomedical practitioners should be consulted; for instance, initially, I wanted to speak with Zulu-speaking psychiatric nurses because of their dual immersion in the worlds of psychiatry and Zulu culture, but I was unable to because of time constraints and ethical issues. Future studies could include perspectives from this population.

Another interesting perspective would be that of biomedical practitioners in rural areas, which I was unable to sample in the present study. Healthcare practice in urban vs. rural areas in South Africa is sometimes radically different, and it would be especially interesting to hear the perspectives on traditional healing of biomedical practitioners who work in rural areas, especially due to the abundance of traditional healers in many of these areas. Indeed, comparing the perspectives of practitioners—both biomedical and traditional—in urban areas with that of practitioners from rural areas could be an interesting future study.

Finally, one valuable perspective not included in the present study is the patient perspective. In future studies it would be interesting to speak with patients who have received psychiatric treatment from Western-trained practitioners as well as patients who have been treated by traditional healers; it would also be valuable to speak with people who have used both systems, either concurrently or separately, to see their perspectives on and understanding of the merits/pitfalls of each.
References


Kirmayer, L. J. (2006). Beyond the ‘New Cross-cultural Psychiatry’: Cultural Biology,


List of Primary Sources


Participant 1, personal communication, April 10th, 2017.

Participant 2, personal communication, April 11th, 2017.

Participant 3, personal communication, April 13th, 2017.

Participant 4, personal communication, April 19th, 2017.

Participant 5, personal communication, April 25th, 2017.

Participant 6, personal communication, April 25th, 2017.

Participant 7, personal communication, April 26th, 2017.

Participant 8, personal communication, April 28th, 2017.

Participant 9, personal communication, April 28th, 2017.

Participant 10, personal communication, April 28th, 2017.
Appendix I: Demographic Data of Participants

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<th>Name</th>
<th>Type of Practitioner</th>
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<th>Age</th>
<th>Ethnicity</th>
<th># Years of Practice</th>
<th>Date Interviewed</th>
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Appendix II: Sample Interview Guides

Traditional Healers

A. Demographic Data

Participant No:
Gender:
Age:
Ethnic Group:
Type of Service Provider:
Years of Experience in the field:

B. Knowledge and Understanding of Mental Illness

1. What does it mean for a person to be mentally ill?
2. Do patients come to you with these types of problems?
3. How do you know if they have a mental illness?
   a. Can you describe how a mentally ill person might act?
4. What are the differences between mental illness and physical illness?

C. Cause/s and Treatment of Mental Illness

1. According to your training or knowledge, what causes mental illness?
2. How do you treat people with mental illness?
3. How long do you usually treat patients for?
   a. Do people come back to you multiple times?
   b. When is a person considered “cured”?
4. What types of mental illnesses have you treated? Give me some examples.

D. Mental Illness Treatment Approaches in South Africa

1. Which other people provide treatment for mental illness in South Africa?
2. How do they treat mental illness?
3. What is your opinion on these treatment methods compared to your own methods of treatment?
   a. Are there any mental illnesses that a doctor cannot cure? Can a traditional healer cure those illnesses?
   b. Are there any mental illnesses that a traditional healer cannot cure? Can a doctor cure those illnesses?
4. Would you ever work with a doctor on a case? Why or why not?
   a. Do you think working with doctors would help or harm your patients?
**Vignettes**

**Depression**
A young mother comes to you because she has not been feeling herself lately. She recently lost her job and her boyfriend (the father of her new child) abandoned her unexpectedly. Since her boyfriend left and she lost her job, she worries about having money to support herself and her baby. She also tells you she does not eat much, sometimes stays in bed the whole day, and no longer enjoys the things she used to enjoy doing. She says she sometimes thinks of ending her own life.

**Anxiety**
A middle-aged man comes to you explaining he is afraid of going to places where there are many people. A few months ago when he was in town, he got mugged by a group of boys and they took all his money on payday. He used to work in town but now does not go to work and is worried about having enough money for rent and food. He used to love going to soccer games but now he does not like them because when he is in large crowds, his heart begins to beat very fast, he starts sweating, and he feels like something bad is going to happen. He rarely leaves his house anymore and has trouble sleeping at night.

**Schizophrenia**
A young man is brought to you by his family because he has been acting strangely. He is often found alone, talking to himself. He says that he hears voices in his head telling him to do things, and has visions of people following him to check what he is doing. He has stopped going to work, rarely takes a bath/washes and mostly stays inside the house. He does not talk to anyone and does not even answer the door when neighbors come by.

**Bipolar**
A young woman is brought to you by her parents who are very worried about her. They say that last week she had an abnormal amount of energy: she barely slept and instead she stayed up very late cooking a lot of food, doing loads of washing, and cleaning the whole house. She says she has “many thoughts coming into her head,” she was talking very quickly without stopping and laughing for no reason. However, this week she has barely gotten out of bed, she is very quiet and sometimes cries for hours at a time. She refused to go to a family party and slept all day instead.

**Vignette questions**

1. What would you say to or do for this person?
2. What is the cause of this problem?
3. If you could not help this person where would you send them for help?
4. Would you call what this person is suffering from a mental illness?
**Biomedical Practitioners**

**A. Demographic Data**

Participant No:
Gender:
Age:
Ethnic Group:
Type of Service Provider:
Years of Experience in the field:

**B. South Africa’s Mental Health System**

1. What is your opinion of South Africa’s current mental health system? Why?
2. Is there more or less of a mental health burden in SA than in other countries?

**C. Experiences with / Opinions of Traditional Healing**

1. What do you think about traditional healers’ ability to deal with mental health issues?
2. How is the way that traditional healers treat mental illness different from the way a biomedical practitioner might treat it?
3. Do you think there are mental health disorders a sangoma could cure but a doctor couldn’t?
4. Do you think there are mental health disorders a doctor could cure but a sangoma couldn’t?
5. If applicable, do any of your patients consult traditional healers? How do you deal with this if it happens, what are some challenges?
6. Why do you think that people continue to consult traditional healers, despite a growing acceptance of Western medicine?

**D. Perspectives on Collaboration and the Study of Cross-Cultural Psychiatry**

1. Do you think there should be formal collaboration between traditional healers and biomedical practitioners?
   a. If so, how would this work best?
2. What do you think about studying cross-cultural psychiatry, in that from the outset we are defining it from a Western, biomedical perspective?
   a. What are some ways to study this properly, and do you think we should be studying it?
Appendix III: Informed Consent Form—English

CONSENT FORM
1. **Brief description of the purpose of this project**
The purpose of this project is to explore ideas and definitions of mental illness from both traditional and psychiatric perspectives. I will be asking you questions about your experiences with treating mental illness.

2. **Rights Notice**
In an endeavor to uphold the ethical standards of all SIT ISP proposals, this study has been reviewed and approved by a Local Review Board or SIT Institutional Review Board. If at any time, you feel that you are at risk or exposed to unreasonable harm, you may terminate and stop the interview. Please take some time to carefully read the statements provided below.
   a. **Privacy** - all information you present in this interview may be recorded and safeguarded. If you do not want the information recorded, you need to let the interviewer know.
   
   b. **Anonymity** - all names in this study will be kept anonymous unless you choose otherwise.
   
   c. **Confidentiality** - all names will remain completely confidential and fully protected by the interviewer. By signing below, you give the interviewer full responsibility to uphold this contract and its contents. The interviewer will also sign a copy of this contract and give it to you.

I understand that I will receive no gift or direct benefit for participating in the study.
I confirm that the learner has given me the address of the nearest School for International Training Study Abroad Office should I wish to go there for information. (404 Cowey Park, Cowey Rd, Durban).
I know that if I have any questions or complaints about this study that I can contact anonymously, if I wish, the Director/s of the SIT South Africa Community Health Program (Zed McGladdery 0846834982)

_________________________  _____________________________
Participant’s name printed  Your signature and date

_________________________  _____________________________
Interviewer’s name printed  Interviewer’s signature and date

I can read English. If the participant cannot read, the onus is on the project author to ensure that the quality of consent is nonetheless without reproach.
CONSENT FORM

1. Ukuchazwa kafushane kwalesisifundo

Inhl sos yalesisifundo ukuqonda ukuchazwa ngesiFA ngabe abaphathi besintu(traditional healers) kanjalo nabelaphi basezibhedlela(psychiatric perspectives). Ngizobuza imibuzo ngolwazi onalo ngokwelashwa kwesifo sengqondo

2. Amalungelo

Njengokomthetho wesikole iSIT lesisifundo sihloliwe sabhekwa abaphathi besikole. Uma uzwa sengathi usengozini yokuzezwa kwezinto ongathandi zaziwe ngawe unelungelo lokumisa ukubuzwa kwemibuzo. Uyacelwa ukuba uthathe isikhashane ufunde okungezansi:

a. Privacy - Zonke izimpandulo zizoqoshwa futhi zivikelwe ukuthi zingabonwa yiwo wonke umuntu

b. Anonymity - all names in this study will be kept anonymous unless you choose otherwise. Onke amagama abantu ayogcinwa eyimfihlo ngaphandle uma wena ungenankinga nokusetshenziswa kwemibuzo naye uzosayina akunikeze elakhophela


I understand that I will receive no gift or direct benefit for participating in the study. Ngiyafunda ukuthi ngeke ngithole isipho noma umvuzo ngokusiza kulesisifundo

Ngiyaphila ukuthi ukuqonda ngikusizisa ngesiFA umfundi obuza imibuzo ungakezile iikheli lesikole esiseduze sakwaSIT uma ngifisa ukuya khona ukuthola iminingwane eminye uma ngiyidinga. (404 Cowey Park, Cowey Rd, Durban).

Ngiyazi ukuthi uma ngingemibuzo nomu izikhala ngathinta umphathi wesikole uZed McGladdery kulenamba 0846834982 ngaphandle kokuzidalula igama lami.

_____________ _____________________________
Igama lami Ukusayina nosuku Iwanamuhla

_____________ _____________________________
Igama lobuza imibuzo Ukusayina nosuku Iwanamuhla

I can read English. (If not, but can read Zulu or Afrikaans, please supply). If participant cannot read, the onus is on the researcher to ensure that the quality of consent is nonetheless without reproach.

Appendix V: Local Review Board Approval Form
**Human Subjects Review**

**LRB/IRB ACTION FORM**

<table>
<thead>
<tr>
<th>Name of Student:</th>
<th>Madeke Molot</th>
</tr>
</thead>
<tbody>
<tr>
<td>ISP Title:</td>
<td>Discourses of Culture and Psychology: the Interface between Cultural and Mental Health in the Treatment of Mental Stress</td>
</tr>
<tr>
<td>Date Submitted:</td>
<td>6 April 2017</td>
</tr>
<tr>
<td>Program:</td>
<td>Durban Community Health and Social Policy - Spring 2017</td>
</tr>
<tr>
<td>Type of review:</td>
<td>Expedited</td>
</tr>
<tr>
<td>Institution:</td>
<td>World Learning Inc.</td>
</tr>
<tr>
<td>IRB organization number:</td>
<td>1ORC0004408</td>
</tr>
<tr>
<td>IRB registration number:</td>
<td>IRB00005219</td>
</tr>
<tr>
<td>Expires:</td>
<td>9 December 2017</td>
</tr>
<tr>
<td>LRB members (print names):</td>
<td>John McGladdery, Clive Bruzas, Francis O'Brian</td>
</tr>
<tr>
<td><strong>LRB REVIEW BOARD ACTION:</strong></td>
<td>✓ Approved as submitted</td>
</tr>
<tr>
<td></td>
<td>—— Approved pending changes</td>
</tr>
<tr>
<td></td>
<td>—— Requires full IRB review in Vermont</td>
</tr>
<tr>
<td></td>
<td>—— Disapproved</td>
</tr>
<tr>
<td>LRB Chair Signature:</td>
<td>[Signature]</td>
</tr>
<tr>
<td>Date:</td>
<td>6 April 2017</td>
</tr>
</tbody>
</table>

Form below for IRB Vermont use only:

Research requiring full IRB review. ACTION TAKEN:

- [ ] approved as submitted  - [ ] approved pending submission or revisions  - [ ] disapproved

---

IRB Chairperson’s Signature: [Signature]  
Date: 6 April 2017
Appendix VI: Consent to Use Form

Access, Use, and Publication of ISP/FSP

Student Name: Madeline Molot

Email Address: maddiemolot717@gmail.com

Title of ISP/FSP: Discourses of Psychiatry and Culture: The Interface Between Traditional and Western Medicine in the Treatment of Mental Illness

Program and Term/Year: SIT South Africa, Community Health and Social Policy, Spring 2017

Student research (Independent Study Project, Field Study Project) is a product of field work and as such students have an obligation to assess both the positive and negative consequences of their field study. Ethical field work, as stipulated in the SIT Policy on Ethics, results in products that are shared with local and academic communities; therefore copies of ISP/FSPs are returned to the sponsoring institutions and the host communities, at the discretion of the institution(s) and/or community involved.

By signing this form, I certify my understanding that:

1. I retain ALL ownership rights of my ISP/FSP project and that I retain the right to use all, or part, of my project in future works.

2. World Learning/SIT Study Abroad may publish the ISP/FSP in the SIT Digital Collections, housed on World Learning’s public website.

3. World Learning/SIT Study Abroad may archive, copy, or convert the ISP/FSP for non-commercial use, for preservation purposes, and to ensure future accessibility.
   • World Learning/SIT Study Abroad archives my ISP/FSP in the permanent collection at the SIT Study Abroad local country program office and/or at any World Learning office.
   • In some cases, partner institutions, organizations, or libraries in the host country house a copy of the ISP/FSP in their own national, regional, or local collections for enrichment and use of host country nationals.

4. World Learning/SIT Study Abroad has a non-exclusive, perpetual right to store and make available, including electronic online open access, to the ISP/FSP.

5. World Learning/SIT Study Abroad websites and SIT Digital Collections are publicly available via the Internet.

6. World Learning/SIT Study Abroad is not responsible for any unauthorized use of the ISP/FSP by any third party who might access it on the Internet or otherwise.

7. I have sought copyright permission for previously copyrighted content that is included in this ISP/FSP allowing distribution as specified above.

Madeline Molot

May 4th, 2017

Student Signature

Date
ISP Ethics Review

The ISP paper by Madeline Molott does conform to the Human Subjects Review approval from the Local Review Board, the ethical standards of the local community, and the ethical and academic standards outlined in the SIT student and faculty handbooks.

Completed by: John McGladdery

Academic Director: John McGladdery

Signature: 

Program: SFH Community Health and Social Policy

Date: 1 May 2017