

**African traditional healers' understanding of depression as a mental illness:
implications for social work practice**

by

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Health Care**

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I would like to acknowledge the following people for their invaluable contributions:

--The traditional healers who participated in my research who imparted their wisdom and wealth of knowledge and experience

-Dr Charlene Carbonatto for her endless support and patience

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ABSTRACT

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Department: Social Work and Criminology

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The research reviews that the majority of Black South Africans will frequent a traditional African healer as a primary means of health care. This may be partly due to the fact that traditional African healer is accredited as offering more affordable means of health care. Traditional African healing has been esteemed in treating the physical, mental and spiritual health of the population. This paradigm is also respected for its holistic approach which stretches beyond sole biological assumptions in the pursuit of optimum health.

Depression is also confirmed as being an illness which is rife in contemporary living. South Africans may also be at an increased risk with regards to this mood disorder, due to harsh psychosocial circumstances including poverty, unemployment and crime. The research offers that the social worker and mental health care professional alike are under increased pressure to obtain 'cultural competence' in understanding how traditional African discourse constructs common mental illnesses like depression. Therefore in light the above, the research attempted to explore an understanding of depression amongst a sample of traditional healers in Johannesburg.

There is little research done on this subject. Therefore a qualitative research approach was adopted. Qualitative research may offer a more reflective space as a point of entry into a subject which has not been explored. The case study research design, specifically a collective case study was used and semi-structured interviews were conducted, using an interview schedule. The researcher interviewed 10 traditional healers. The interview aimed to explore how traditional healers understand depression.

The research used a content analysis to draw common themes from the transcribed interviews with the participants who formed part of the sample, selected by means of purposive sampling. The themes derived from the interviews offer some reflections on the traditional healers' understanding of depression. These themes included: relevancy of depression; distinctions between depression and sadness; intuitive assessments of depression; external circumstances and psychosocial circumstances; relevance of biomedical interventions; treatment by the African traditional healer; counselling; supernatural and spiritual influences; punishment; depression experienced as a collective vs. individualistic cultural experience; somatisation and specific emotional difficulties related to the vocation of traditional African medicine.

The research concluded that the traditional healers' conception of depression was in a state of flux and was very much dependent on the individual interpretations by the traditional healer. This appeared to be influenced by the level of the traditional healers' acculturation into westernized culture and exposure to biomedical interventions. The relevancy of the concept of depression was viewed as being both redundant and ripe in relevance by the sample. Depression and sadness could not always be distinguished between. However, there was a conceptualization of depression as being a more intense and severe form of sadness. Intuitive assessments of depression were generally adopted as opposed to exploring specific diagnostic criteria. Cognitive distortions such as 'thinking too much' and external circumstances were recognized as significant contributors. Depression was mostly indirectly recognized as an illness. Allopathic medicine was both rejected and held in high regard. Counselling was viewed as being necessary. This was not always adopted by the traditional healers. The spiritual significance was graded on a subjective spectrum of making meaning of depressive experiences. However the ancestors were still revered in all assessments and interventions. Depression was viewed on a continuum between individualistic and collective cultures. There were no significant somatic reports. In a nutshell the research concludes that there is no unified perception of depression, but highlights some common cultural variables. The research specifically highlighted the psychosocial and spiritual qualifying factors which may differentiate and qualify this paradigm from other biological and allopathic interventions.

The research paves the way for further research to be done in this area.

Recommendations are made for social workers and mental health care professionals alike to become more fluent in traditional African healing discourse in the area of mental health and depression in order to understand their clients from the African culture.

LIST OF KEY TERMS

African

Traditional healer

Traditional medicine

Depression

Mental illness

Understanding

Social worker

Allopathic medicine

Spirituality

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CHAPTER 1- GENERAL INTRODUCTION

1.1 Introduction

In South Africa, it is reported that over 80% of the population will frequent a traditional healer before visiting a medical doctor (Nevin, 2001:18). Tangwa (2007:41) affirms that traditional medicine has been accepted as being more attractive to many South Africans than conventional medicine. This may be because it has established itself as being a more accessible and affordable means of health care. Traditional medicine has also been appreciated as being sensitive to psychological, environmental and spiritual influences (Pretorius, 2004:533). This paradigm may therefore be described as having stretched itself beyond biological manifestations of medical practice. It may also be further argued that mental health care has been in the hands of spiritual and traditional healers for centuries (Msotho, Louw, Calitz, & Estehuyse, 2008:35). It is in partial recognition of this that the ANC National Health Plan has stipulated that traditional healing will be a recognized part of health care in South Africa (African National Congress, 1994:15). Furthermore the Department of Health has affirmed in the White Paper for the Transformation of Health Systems in South Africa (1997) that traditional healers should be recognized as an integral part of the primary health care system. Therefore the relevance of traditional healing in South Africa is imminent. It should be noted that indigenous healers of South Africa are to be referred to in this research as traditional African healers.

The World Health Organization (1998) postulated that depression would be the most common illness in the world by the year 2010. Therefore it can be concluded that mood disorders or depression may be viewed as another health trend on the rise. It is regarded by the World Health Organization (1998) as the common cold of mental illness. It is further predicted that it will be the second leading cause of disability and heart disease. Indeed this prediction will also raise its head in the South African context. The reality of depression in South Africa is reinforced by Triant (2002) who has recognized that South Africa is a fertile ground for mental illness. This reality is partially recognised due to the host of social problems that South Africans have to contend with. This includes a legacy of social injustice from Apartheid including: poverty, unemployment, crime and HIV. Triant (2002) affirms that reports of clinical depression from primary health care settings may range from 14%- 49 %. These statistics may even be higher. Triant (2002) elaborates that depression is generally not recognized and adequately treated at primary health care level. Patel (2001:481) further affirms that depression is a cause of morbidity and disability in developing countries. Therefore depression is an issue of high priority in South Africa. This is therefore an important issue which warrants the attention of the mental health care worker and social worker.

Therefore as a means of introduction, both depression and traditional African healing are pertinent topics which require further attention. Thus by extension, the relationship between traditional healing and depression becomes an important area of investigation in South Africa. This is in recognition that there are many people suffering from depression in this country. The fact that the majority of people go to traditional healers for treatment, reinforces the relevance of research in this field. Furthermore there does not appear to be much research

in terms of how traditional African healers define or position themselves in relation to depression. This further draws attention to the necessity of research in this area. Similarly the social worker needs to be cognizant of these variables, when working with a depressed client, who has frequented a traditional healer. A traditional African perspective on depression offers essential cultural and contextual information which the social worker needs to have readily available in his /her 'toolbox'. Research in this area should improve and further sensitize the social worker's assessment and intervention. Perhaps a better understanding of traditional African medicine in the area of mental health may also lay the foundation for future collaboration between other mental health care workers and the traditional African healer.

1.2 Rationale

Culture shapes the experience and expression of illness and emotional distress (Kirmayer, Groleau, & Guzder, 2003:145). Thus it becomes an important area of investigation. Furthermore as offered by Nevin (2001:18) there is a need for an increased invested research in the role played by social work, psychology, religion and culture in all aspects of medicine and in the healing process. Therefore by extension it is most relevant to study the way in which traditional African healers conceptualize depression and other mental health issues. This allows for in depth insights into how culture may colour the experience of depression for many South Africans. It specifically allows for an exploration as to how traditional African healers derive meaning of the mental health issue of depression.

The meaning made by traditional African healers may present a different picture of depression to the social worker and mental health care worker alike. Jackson (1991:59) postulates that western perspectives or modern clinical psychiatric discourse may highlight psychological factors in depressive disorders. However, non western perspectives/alternatives or traditional medicine may highlight somatic complaints. In Zimbabwe the word depression may signify an illness which may present with somatic complaints rather than an emotional experience (Patel, 2001:481). Therefore westernized conceptions of depression may not correspond with traditional African perspectives. Patel (2001:481) elaborates that there is often no equivalent term for the concept of depression or the experience of emotional distress in African languages. There is therefore often a cultural incongruity as to how depression is constructed / understood by all cultures. It is important to gain an understanding of how traditional African healers conceptualize depression. If the reality of depression is imminent, as delineated in the introduction, the question remains as to how this is received and acknowledged by traditional African healers. The concept of depression may in fact not even be recognized by African traditional healers at all. Therefore the social worker cannot only adopt conventional allopathic constructions of depression when working with clients from a traditional African perspective. Traditional African medicine and the traditional African healer may even negate an experience of depression as an illness, disorder or even a primary emotional experience. Therefore further research is warranted to investigate the relationship between them.

It is not the intention of this research to impose westernized psychological frameworks or modern medicine perspectives on depression. The researcher rather hopes to allow for uncovering a traditional African understanding of depression, and assess to what degree, it is viewed as a mental illness. This should allow a platform for alternative and traditional frameworks to stage their own theories. It may also benefit conventional practitioners to become more theoretically fluent in alternative medical practices. Indeed this notion, is

reinforced by Beiser (1991:272) who recognizes the importance for medical doctors to understand how a patient from a traditional African context may express distress. The experience of distress will obviously be filtered through a cultural frame of reference. The researcher believes that it is equally important for social workers to understand this frame of reference. Research in this area can only enrich medical doctors' and social workers' intervention with patients. The fact is repeated that it allows for a more in-depth understanding of a patients' cultural experience. Therefore without this understanding certain culturally relevant symptomatology may be dismissed or fail to be recognized. Equally, purely westernized discourse may be imposed on the African client.

Beiser (1991:272) further proposes that lack of research in this regard may result in incomplete assessments, incorrect diagnoses, inadequate or inappropriate or failed treatments. Once again, the researcher argues that an investigation is essential to uncover how the traditional healer may or may not recognize or treat depression. It further insists that its endeavour is pertinent for all mental health practitioners and social workers alike.

Thus it is now obvious that the social work and other helping professions need to understand culture and how it impacts mental health. This has been a basic tenet of social work practice which has been upheld by the profession. It has been for example proclaimed that the social worker aims to work from the heart of the community and prioritizes the psychosocial context of the individual (Dhooper, 1997:134). Therefore the researcher emphasizes the fact that it is essential to gain an understanding of how the traditional African healer recognizes and treats depression. The researcher also confesses that on a personal level, she has found there to be a lack of knowledge in this area in her own practice with depressed South African clients. It is therefore suggested that this may therefore be a universal experience for many social workers in South Africa. This idea is further confirmed by psychologist and traditional healer, Professor Lipshitz (2008). He affirms that there exists great diversity among cultural groups within African culture. In his expert opinion, he insists that mental health practitioners need to familiarize themselves with these processes in working with the people of South Africa. Therefore the need for social workers to get better acquainted with traditional African cultural processes is indisputable.

Indeed the rationale of the study is for social work to gain cultural competence in the field of mental health. This is defined as 'a process through which health-care professionals integrate knowledge, attitudes and skills that enhance effective interactions with others to continually strive to effectively work in culturally diverse contexts (De Villiers & Herselman, 2004:27).' African traditional healing or indigenous medicine will shape an individual's experience and treatment of depression. It proposes that certain depressive symptoms may be completely absent or intensify from culture to culture (Msotho, Louw, Calitz, Estehuyse, 2008:3). The authors recognize that it is limiting to impose western conceptions/understandings of depression without allowing space for cultural variation and interpretation. Therefore there is a need to enhance an understanding of culture in areas of mental health (Kirmayer, Groleau, Guzder, Blake & Jarvis, 2003:151). The researcher argues that western research or clinical psychiatry cannot always be given blind authority.

Furthermore Tangwa (2007:41) emphasizes the importance of carrying out research on traditional medicine, 'in order to improve and demystify its therapeutic qualities; to extend intellectual property laws to cover traditional knowledge and biodiversity, and to create a framework, associations, scientists, policy makers, patients, community leaders, members of communities.' Therefore this research aims to carry out its agenda with this intention. It aims

to explore a traditional African perspective to extend knowledge and awareness in this area of mental health. This allows for the transmission of knowledge and initiates the creation of new possible theoretical frameworks of depression in the area of traditional African medicine.

Therefore because of a lack of knowledge in traditional healers' understanding of depression, it is necessary to carry out further research in this area. It is again essential that the social worker be equipped with this knowledge in working with South Africans who have adopted traditional African culture, and frequent a traditional African healer.

1.3 Problem formulation

The problem remains that there is a lack of understanding among mental health professionals including social workers as to how traditional African culture defines or constructs an experience of depression. There is little if any knowledge as to how the traditional African healer understands depression. This is particularly relevant in South Africa, as it has been reiterated that traditional African medicine appears to be the first choice of health care for many Africans (Bruce, 2002:161). There is therefore a need to explore how these people may be treated by a traditional healer when reporting depressive complaints. Ross and Deverell (2004:2) reflect that culture will define values, beliefs and patterns of behaviour, as well as how an individual conceptualizes illness, treatment and recovery. This is reinforced by Kessing in Tjale (2004:31) who defines culture as a 'system of ideas, system of concepts and rules and meanings that underlie and are expressed in the way human beings live. It therefore denotes how individual's view the world, experience it emotionally and conduct their behaviour in relation to people, supernatural forces, gods and the natural environment.' Therefore the research contests that an alternative cultural perspective will influence how an illness or depressive episode or even an experience of distress, is experienced and understood. There is therefore a need to unpack how this translates in a cultural context. As previously stated this is something which is vital and has not been adequately explored in the South African context.

Culture will indeed channel an experience of malaise in diverse manifestations. This remains an essential area of knowledge for the social worker to understand. Helman (1996:264-267) denotes that each culture will prescribe individuals ways in which they become ill and choose appropriate treatment. Therefore according to Helman (1996: 264-267) culture may allow for specific definitions of normality which may include speech, behaviour and even verbal expressions of distress. Somatisation may for example also provide a means of patterning psychological distress which encompasses physical symptoms (Helman, 1996:265). Cultural manifestation of distress or illness may not fit in with dominant depressive discourse. Research into indigenous/alternative/ traditional propositions is a pressing area of investigation for all mental health professionals, including social workers. Conventional medicine recognizes the biological basis for depression or mood disorders. The biological approach as offered by western psychiatric medicine precludes that mental diagnosis should remain consistently defined. This is because it has a biological basis. However, Helman (1996:256) relates that mental illness is often socially constructed. Society defines which symptoms and behaviours define a mental illness. The very assumption of depression as a mental illness may invalidate a traditional African understanding of depression. It may even be better, as stated by Foster and Anderson (in Helman, 1996:257) to explore symptom patterns rather than diagnostic categories. This is something the social worker needs to pay attention to when working with clients in the South African context. The

researcher suggests that the possibility that a diagnosis of a depressive episode may not be recognized by traditional African discourse. Therefore there appears to be a dilemma in meshing the world of traditional African culture and conventional western medicine. Therefore the researcher bears testimony once again to the fact that there is a need to gain more knowledge of how depression is understood by traditional African medicine.

The unique cultural characteristics of African traditional medicine need to be elucidated. For example central to the cultural influence of African traditional medicine is spirituality (Pretorius, 2004:553). This has a huge influence in how illnesses and general life experiences, like depression may be understood. Furthermore psychiatry and psychology have made little room for a spiritual influence (Fernando, 2003:115). Ideas tend to be conceptualized around mental illnesses, and mental processes. As previously stated western medicine roots itself in the scientific paradigm and uses a biomedical practice to account for illness and disease. Traditional medicine on the other hand operates from a spiritual indigenous realm and aims to uncover psychological, environmental or spiritual disharmony (Pretorius, 2004:553). Therefore spiritual influence is an essential ingredient in the traditional African pie of illness (Pretorius, 2004:553). At the heart of social work practice is the understanding of the individual in context. Therefore it would be essential for the social worker to take into account this spiritual influence in an attempt to understand depression from a traditional African medicinal standpoint. The researcher believes that it would be short sighted for modern medicine to project its subjective frame of reference onto traditional and alternative frameworks. This may undermine or neglect traditional African medicine's prioritization of spirituality in illness and health. Therefore by extension, the spiritual may be one branch of a traditional African understanding of depression which has not been adequately understood by the secular world and modern medicine alike. Once again it is repeated that there is need to explore whether this spiritual influence does creep into traditional African healers' understanding of depression. This is necessary for all mental health professions including social work to understand in their intervention with regard to depression.

Spiritual influence is not the only area of disparity in the terrains of traditional African healing and conventional medicine. The emphasis on the self also has a disproportionate cultural meaning and relevance. Fernando (2003:123) elaborates that western psychology recognizes the importance of self, ego and the need to boundary the self. Western psychopathology will locate mental illness in this framework. This negates a conceptualization of self born from the interconnectedness of the individual with the 'other.' This conceptualization carries a great deal of weight by traditional African frameworks. The African sense of self is understood as being part of the collective in relation to the other (Fernando, 2003:123). Therefore there is a definite incongruity between notions of self from these different contexts. This will presumably impact understandings of depression. There is little insight as to how this may influence or shape a depressive experience. For example the collective sense of self may not recognize a personal individual depressive experience. Once again, social work and other mental health professions need to understand the unique characteristics of African identity and notions of self. This will allow for broader insights into this culturally specific experience of depression.

In summation, it is problematic to merge westernized perspectives of modern medicine, social work, psychiatry and psychology and traditional African discourse in the area of mental health. The experiential, philosophical, behavioural and theoretical components that define depression may be culturally specific. Furthermore, it is also offered that mental

illness is socially constructed. It cannot therefore be universally categorized. There needs to be space made for alternative cultural classifications. This allows for traditional African cultures to be given their due authority. Specifically westernized conceptions may ignore the spiritual and holistic components fundamental to traditional African perspectives. The research needs to be implemented precisely because there is a lack of specific theoretical input regarding traditional African healers' understanding of depression.

The researcher further believes that a social work inquiry may bring these two worlds together by offering a platform for a traditional or indigenous African inquiry into mental health issues. Social work is an excellent field to research this, as previously reflected it prioritizes the psychosocial context. It may be proposed that the holistic investment and treatment of the individual may indeed allow for a more respectful intervention. This may serve as a lesson for other healing modalities. It is essential that health care professionals and social work maintain a broader understanding of the context and current conceptualizations and understandings around South African mental health issues. This is a requirement of conscience. In this way all South Africans will be understood, respected and treated by the mental health practitioners and social workers. Therefore there is a lack of knowledge by mental health professionals including social workers as to how traditional African healers understand depression.

1.4 Aims and objectives

Webster's Third International Dictionary in Fouche and De Vos (2005:104), describes the goal and objectives as 'the end to which aim or ambition is directed.' De Vos in Fouche and De Vos (2005:104) elaborates that the goal is the 'dream' or desired outcome of research intention.

Therefore the overall aims of this research may include the following:

- To explore how traditional healers understand the concept of depression or distress.
- To allow for the social worker and other mental health professionals to gain a better appreciation of other paradigms beyond the medical model.
- To examine how traditional African healers locate meaning with regard to the concept of depression.
- To highlight disparities and similarities between traditional African views and westernized allopathic concepts of depression or mood disorders. The very experience of distress or depression may be a feeling or a mood with its own unique cultural manifestations.

The objectives represent the steps that need to be taken within a certain time span to obtain the goal (Fouche, 2005:105).

The objectives include the following:

- To conceptualize mental health and depression and the treatment of depression from both a westernized and an African traditional paradigm.
- To explore how 'depression' is understood and treated by African traditional healers.
- To make recommendations for social work and other mental health intervention for further research in the area of mental health, culture and traditional African Medicine.

-To offer insight into relevant contextual cultural issues for social workers and other mental health care providers when working with individuals in a mental health context who follow a traditional African cultural paradigm.

1.5 Research question

Ratele (2006:540) reports that the ‘research question’ states the research objective in the form of a question. Mazabaum (2006:29) recognizes that the research question is much broader than a hypothesis. It is less structured and does not have a positivistic intention. A research question is chosen over a hypothesis as the research is engaging in an inquiry. It does not have a proposed answer. The proposed research question is constructed as follows:

What is the understanding of depression as a mental illness by traditional African healers?

Mazabaum (2006:21) states that the research design is the blueprint to guide and plan the data collection methods and data analysis to answer the research question.

The research will offer an outline of the type of research used and methodology including the research design in Chapter 3.

1.6 Research methods

The research approach adopted is qualitative and exploratory in nature. Its aim is to study the phenomenon of traditional healing in relation to a conceptualization of depression. The research design adopted is a collective case study.

The population was traditional African healers in the Johannesburg Metropolitan area. Clear descriptions of these terms will be described in ‘definitions of key concepts’ in the latter part of this chapter. At this time the population is understood as being comprised of African traditional healers. Non-probability sampling was used and the sampling method was snowball sampling. This is used when individuals may be hard to reach. In snowballing the researcher is able to collect information from a few subjects of the target population. These members then put him/her in contact with other members of the population (Strydom & Delpont, 2005:330).

The data collection method adopted was one-to-one interviewing, using a semi-structured interview schedule and a tape recorder with the permission of the participant. The data analysis involved a process of coding. The data was categorized and coded into themes. The research methods, methods of data collection and analysis, as well as trustworthiness will be discussed in detail in Chapter 3.

1.7 Ethical considerations

The researcher handed out informed consent forms to the sample before conducting research. This was done in order to ensure that ethical considerations were taken into account. The forms emphasized that the participants are free to terminate the interview process at any time. It was also stressed that there were no wrong or right answers. The participants were encouraged to ask questions they did not understand. However, particular attention was also given to the fact that the participants did not need to answer any question with which they were not comfortable. As previously mentioned, the participants were also encouraged to add

to or elaborate on any aspect they deemed relevant. The researcher spent time explaining the process of the research and interview. Efforts were also made to establish the researcher's trustworthiness, and protect issues around confidentiality and anonymity. It was explained to the participants that the interview would be recorded in an audio form. The researcher would however omit any identifying information when writing up the data. The researcher also debriefed the participants after the interview, and offered referrals for counselling. The researcher however did not find that any of the participants experienced the questions harmful in any way. The questions did not evoke emotional distress from the participants. The researcher left her contact numbers on the consent forms. This was done so that the traditional healers could contact her any time of day or night should they need to be referred for counselling.

1.8. Definition of key concepts

1.8.1 The traditional African healer

According to World Health Organization in Pretorius (2004:536) a traditional healer is the following:

'someone who is recognized by the community in which he lives as competent to provide health care by using vegetable, animal and mineral substances and certain other methods based on the social, cultural and religious background as well as the prevailing knowledge, attitudes and beliefs regarding the physical, mental and social wellbeing of the disease and the community.'

Sangoma (2007) confirms that a traditional healer or sangoma is 'a practitioner of herbal medicine, divination and counselling.' The research adopts the definition as cited as above. There are different types of traditional African healers. These may include: the diviner, herbalist and faith healer (Wikipedia, 2007). The diviner will be used in this study.

According to Pretorius (2004:531) the diviner uncovers the cause of the illness and conveys messages from the ancestry or spirits. They may use divination objects or prophecy to achieve this objective. The research will focus specifically on diviners. However, many traditional healers do not practice one modality. There is often much overlap in the roles adopted. There may therefore be no clear distinction between the different types of traditional healers. The research will rely on the individual traditional healer's own appraisal of his/her vocation as such. The research will therefore not ask for any proof of training or any other credentials.

1.8.2 Mental health and traditional African medicine

The researcher will explore how the traditional African healers in the sample understand depression. Depression may not necessarily be conceptualized as a mental illness. However, in order to conceptualize depression, it is important to understand how mental health is conceptualized by traditional African medical discourse. Mental illnesses are often couched in theory of misfortune, ancestry and witchery (Ngoma, Prince & Mann, 2003:353). They are not necessarily viewed as diseases or disorders, but are rather consequential of social, physical, religious or magical disharmony. The researcher will adopt this conception of mental illness. Therefore it is only logical as argued by Maiello (2008:248) that treatment is holistic and involves biological, psychological and spiritual dimensions.

In summation the expression, behaviour, or meaning made of distress or a ‘mental illness’ may be culturally specific. The research will rely heavily on this insight throughout its endeavour. Depression will also be understood in a similar vein. This may be in direct contrast to other biological and psychological frameworks which may metaphorically speaking, sweep this insight under the carpet.

1.8.3 Depression

Depression falls under the broader category of mood disorders. According to Barlow and Durand (2005:206) mood disorders are disorders which are characterized by a pervasive deviation in mood. Mood Disorder defines a mood disorder as a condition where emotional mood becomes distorted (Wikipedia, 2008). A diagnosis is reached when at least four of the following symptoms are experienced: changes in appetite and weight, changes in sleep, pervasive lack of energy, feelings of guilt, difficulty making decisions and continuous thoughts of death (Zucker, 2003:33). Barlow and Durand (2005:206) elaborate that there may be other feelings of worthlessness and indecisiveness.

The researcher is of the opinion that to merely focus on physiological conceptualizations of depression undermines a traditional African perspective. The researcher does not necessarily adopt biological assumptions of depression as a universal truth. She rather explores depression as a social condition. The researcher adopts a conceptualization of depression which is socially defined and fluid. It has been reflected upon the fact that the researcher allowed for the possibility that there may not be a conceptualization of depression at all. She will therefore use terms like distress, stress or sadness, should the traditional healer interviewed not relate to the word ‘depression.’

1.8.4 Understand

The word ‘understand’ is defined as to be aware of the meaning of or to impute meaning and character to that which is not explicitly stated (Understand Dictionary, 2003). Understand is also understood as to grasp the significance, the implications or importance of (Dictionary, 2006). The researcher’s definition will essentially use the word understand to denote the meaning made of something. In other words the researcher asks what is the understanding or the meaning made of depression by the traditional African healer.

1.9 Limitations of study

The researcher will now make mention of some of the limitations of this study.

The research is qualitative in nature, and therefore there may be a lack of generalisability and transferability.

The results cannot be offered as fact. It is rather a descriptive study of a group of traditional healers. Therefore the results are thus very specific to this sample.

The research was also conducted in English, although, the sample was given the option of a translator. This may still be seen as a limitation. A great deal of authentic cultural knowledge and description may be lost in translation. Cultural nuance may be compromised when the traditional healer tried to explain key issues in a language other than the vernacular.

The content of the research may also have encountered other challenges. The traditional healers may not have felt comfortable to fully disclose to the researcher. They may have been guarding sacred cultural knowledge for a host of reasons. The possibility exists that some testimonies may be private and privileged. There may have been fear that knowledge shared in this arena may be contaminated. They may also be skeptical as to whether the researcher being of a different culture, would be able to understand their cultural knowledge and context. There may also have been fear of being discredited or not believed.

Issues regarding generalisability also warrant further attention. None of the traditional healers worked solely as traditional healers. They also worked in more urbanized contexts. Therefore research obtained may be limited to this sample.

1.10 Contents of mini-dissertation:

Besides this chapter, this mini-dissertation will contain the following chapters:

Chapter 2: African traditional healers' understanding of depression as a mental illness: implications for social work practice; Westernized conceptions of illness versus indigenous African frameworks and traditional indigenous healing and mental illness; Other topics include depression, mental illness, traditional healing, and treatment.

Chapter 3: Research methodology and findings

Chapter 4: Summary, conclusions and recommendations

Subsequently, chapter 2 will follow.

CHAPTER 2

AFRICAN TRADITIONAL HEALERS' UNDERSTANDING OF DEPRESSION AS A MENTAL ILLNESS: IMPLICATIONS FOR SOCIAL WORK PRACTICE

2.1 Introduction

The researcher aimed to explore traditional healers' understanding of depression. As means of introduction, it is necessary to primarily highlight the plight of many black South Africans who suffer from depression. This should assist in establishing a rationale as to why more research is needed to investigate the traditional African healers' understanding of depression.

Depression and mental illness are a pertinent reality in the South African context (Triant, 2002). Despite this, the research proposes that there has not been adequate research on depression in a South African context. The researcher maintains that traditional healers' understanding of depression is indeed one of various aspects of depression, which needs to be explored. It recognizes that there is an overall need for more information on the experience of depression for the black South Africans. For example there is surprisingly little research on the prevalence of depression amongst black South Africans (Depression and Anxiety Support Group, 2009). According to the Depression and Anxiety Support Group (2009), a non-profit South African organization, this is largely due to cultural and language differences. However, according to the group's research, depression may present at primary health care clinics in around 18% of cases. This is said to be an underestimated percentage. It is offered that many general practitioners are said to misdiagnose depression in about 33-50% of cases. Dr Sebolelo Seape who works for the South African Depression and Anxiety Support Group, confirms that this may be due to the fact that many patients will focus on their physical symptoms, rather than their emotional experience (Depression and Anxiety Support Group, 2009). Therefore, in this instance, the emotional devastation brought on by a depressive episode and its diagnostic validity is often redundant. It therefore does not get adequately recognized and dealt with. This serves as a mere example of how the condition of depression is not being dealt with properly in the South African context.

The research is not undertaking to investigate the general practitioner's diagnosis of depression at a primary health care level. However, it begs the question as to what is happening in the 'kraal' of the traditional African healer, if it already being poorly dealt with on a primary health care level? The example above describes how the medical doctor is not adequately diagnosing depression for many Black South Africans. The researcher therefore also highlights the need to question the nature of the care administered by the main custodians of health in South Africa. This is of course in the very palms of traditional healers. The researcher's interest rests not so much on the quality of care, but rather in the nature, or philosophical 'texture' of the care. The researcher asks how do traditional healers understand depression?

This question should figuratively speaking 'raise the eyebrows' of many a concerned South African. This means that by virtue of being black in the South African context may, at this point in time, increase risk factors associated with mental illness (Depression and..., 2009). The Apartheid legacy of informal urbanization and political uncertainty is said to have contributed to poverty, violence, lower social economic levels and disturbed social relations (Depression and..., 2009).

Once again, the research wishes to repeat the notion that if depression is indeed very prevalent in the South African context, there is an increased need to understand how it is recognised and treated. It has been offered as an example that depression is not being adequately addressed on a primary health care level. It has been alluded to that the traditional African healer, rather than the medical doctor, will be the first port of call for many South Africans (Tangwa, 2007:41). Smet (2000) testifies that the traditional healer is recognised as a principal professional in health care for many Africans. Therefore there is a pressing need to understand how African traditional healers understand depression. Therefore as a starting point it is necessary to define the concept of the traditional African healer.

2.2 Definition of key concepts

2.3.1 The traditional African healer

Pretorius's (2004:536) definition of the indigenous/ traditional healer is the most succinct summation of the general role played by the traditional healer. The traditional healer is defined as: 'someone who is recognized by the community in which he lives as competent to provide health care by using vegetable, animal and mineral substances and certain other methods based on the social, cultural and religious background as well as the prevailing knowledge, attitudes and belief regarding the physical, mental and social wellbeing of disease and disability in the community.'

The African traditional healer therefore provides a culturally relevant way of interpreting the cause and timing of illness (Gilbert, Selkow & Walker, 2002:50). The indigenous healer is also credited in working from a holistic perspective.

Mutwa (2003:27) affirms that 'where illness and madness have come, the sangoma knows that the power of the universe is disrupted and must be balanced and restored to harmony.' The job of the traditional healer is essentially to restore this balance. The traditional healer achieves this, by exploring and treating illness in relationship to the natural, social, supernatural worlds. Karimi and Eschenauer (2006) describe a traditional healer as being given the duty to 'sniff out' the source of the psychological or physiological cause of the illness. Healers also often provide moral and social guidelines to prevent development of mental disease (Pretorius, 2004:533).

The traditional healer is esteemed in providing culturally relevant explanations for the cause and timing of an illness (Helman in Gilbert et al., 2002:56).

In summation, an illness will occur when there is disharmony between the body, physical, social and supernatural environments. It is the duty of the traditional healer to explore this disharmony and advise accordingly. This is done in accordance with traditional African culture and philosophy.

It is apparent from the above definition that traditional healers play a fundamental role in safeguarding the physical and mental wellbeing of their communities and people. Furthermore, Hewson (1998:1029) recognizes that traditional healers are renowned for their personal involvement in the healing process, which may allow for a deeper sense of connection and fulfillment. As noted by Hewson (1998:1030), the indigenous healer will not distinguish between caring and curing. This may make all the difference in providing effective care. This may be seen as a means of aiding the healing process. Indigenous healers

have been serving their communities for centuries and are said to derive communal respect (Robertson, 2006:87).

2.3.2 The diviner

It may be useful to distinguish between the different types of traditional healers, in order to become better acquainted with the world of the traditional healer. The diviner is perhaps the most well known type of traditional healer. The diviner is known by different names by the different cultures in South Africa. Amagqira in Xhosa; Ngaka In Northern Sotho; Selaoloi in Southern Sotho; Mungome in Tsonga and Izangoma in Zulu. This indigenous healer is often referred to as a sangoma from the Zulu origin of the word (Pretorius, 1999:250).

The diviner is typically called by the ancestors to become a healer. They may experience 'tawahsha', which is experienced as being characterized by physical and mental pain (Louw & Pretorius, 1995:43). It is understood as a 'calling' to become a traditional healer. Symptoms may include anxiety, depression physical aches and pains, palpitations and insomnia (Louw & Pretorius 1995:43).

The diviner may typically throw the bones as their primary instrument of practice. Mutwa (2003:26) states that the throwing of the bones may be used to diagnose illness. The bones are used to identify the presence of spirits around a sick person, resentful ancestors or evil spirits that may have been sent by a sorcerer (Mutwa, 2003:26). The configuration of the bones has thematic relevance. This is used by the traditional healer to gain insight into the individual's situation (Hewson, 1998:1030). The bones may offer insight as to how an illness manifested. The illness may possibly be consequential of breaking taboos or weakening of energy (Mutwa, 2003:96). The bones are usually thrown like dice onto a mat or dried animal skin. Bones may refer to actual bones. These may be the bones of a goat used and eaten in the healer's graduation ceremony when training is completed.

The diviner may also use other practices in diagnosis. Dance, drums and chant may be used to gain insight into the individual's situation (Hewson, 1998:1030). The diviner will try to gather as much information as possible on current symptoms when making a diagnosis. He/she will then try to gain an in depth understanding of the individual's psychosocial context to explore what may be causing current symptoms. In conclusion, the diviner appears to embody many of the characteristics of what one imagines, when conjuring up an image of a traditional healer. It appears that what distinguishes the diviner from the other subtypes is divine communication with ancestors or spirits.

2.3.3 The herbalist

The herbalist diagnoses and offers treatment for illness and disease (Pretorius, 2004:533). The diviner and the herbalist primarily differ in terms of 'calling'. The diviner receives a calling to become a traditional healer. The herbalist may not necessarily be called by the ancestors to undertake a vocation as a healer. The herbalist may decide to take on work in healing, based on his/her own free will (Louw & Pretorius, 1995:43). Therefore the herbalist may be trained without receiving a calling. Common ailments such as headaches and coughs are believed to be able to be treated by natural medicines by dispensed by the herbalist (Smet, 2000:10). Using herbs to heal is believed to be the most ancient form of medical practice (Blackherbals, 2006). Mutwa (2003:27) offers that herbalists may use herbs, seeds, roots, minerals, insects, shells, smoke or eggs. Herbal teas, snuffs, salves and

massages may also be used. Medicines used may take on strong symbolic meaning. Plants are used in symbolic, ritualistic and spiritual ways to cure illness (Native Remedies, 2010).

In conclusion the herbalist could perhaps be likened to a traditional African homeopath. The emphasis seems to be less on divine communication and instruction, as in the case of the diviner. The herbalist is rather involved in administering herbal medicines for the treatment of symptoms.

2.3.4 The faith healer

The traditional healer may also take the form of a faith healer or prophet. This may be the result of the joining hands of traditional medicine and conventional medicine. This type of traditional healer has been shaped by Christianity so that it is reconcilable with traditional culture. Pretorious, De Klerk & Van Rensburg in Lambat (2004:4) state that the faith healer treats patients within the framework of the African Independent Churches. Crawford and Lipsedge (2004:138) describe the faith healer as ‘one who prays for the people.’ Peltzer (1999:387) describes the faith healer as one who is able to ‘heal, predict and divine.’ The faith healer is not a traditional healer per se; however s/he may share the same belief system about health and illness as traditional culture (Pretorious, 2004:540). They may use prayer, water and candle light when treating a patient. This is used as ‘faith’ is put in the supernatural or spiritual to cure illnesses (All About God, 2010).

The research speculates that the faith healer may indeed appeal to many Black South Africans occupying space in a modern world. They may bridge the world of traditional African wisdom with more modernized forms of worship through the church. Once again, it is key to emphasize the divine. In South Africa faith healing appears to be mostly in the hands of the Apostolics, and the Zionist groups (Peltzer, 1999:387). Interestingly enough, according to the Human Research Council (2010) faith healers tend to be consulted less than other traditional healers.

The distinction between the different types of traditional healers does assist in gaining some background insight into the world of traditional healing. However, Pretorious (1999:250) recognizes that there is often much overlap between the roles of traditional healers. This has already been alluded to in the previous chapter. Therefore it is often not simple to group the traditional healer into distinct categories. It is for this reason that the research will not strictly distinguish between types of traditional healers in its sample.

2.4 The theoretical framework

The research works from the premise of the Health Belief Systems model. This model explores the perceived seriousness, susceptibility, benefits and barriers in understanding health related behavior (Health Belief Model, 2012:33). It may be described as a tool to be used to understand individual’s perceived health related behavior (Boskey, 2010). Forbes (2002) recognizes that there is the need to explore whether ethnic cultural beliefs impact health related issues for African people. Therefore the research makes use of a Health Belief Systems model, which specifically focuses on how the traditional healer perceives or understands depression. This may offer insight into how mental health and depression is negotiated. The research also highlights implications of this negotiation. The research uses content from the sample’s interviews to unpack the traditional healers’ perceptions of the seriousness of depression. For example the research questions whether the traditional healer

recognizes the difference between depression and sadness? It further asks the social worker and mental health care worker to be attuned to the implications of this. The researcher investigates what the traditional healer may deem as factors which may increase susceptibility to a depressive episode. The researcher indeed aims to gain clarity into how the traditional African healer understands depression, in order to highlight socio cultural variables which may impact or shape a depressive episode from a traditional African context. In this way, the researcher attempts to better understand the health related beliefs and behavior of depression from the perspective of the traditional healer.

The researcher also uses a bio psychosocial model as a fundamental theoretical framework. The bio psychosocial model reflects on health and illness as a complex interaction between psychological, biological, social and cultural factors (Nursing theories, 2012). Consequently the researcher concurs that health cannot be defined by one single variable. The researcher recognizes that depression cannot be purely understood by modern medicine, or psychology. It presumes that the ‘slippery slope’ of depression can only be understood by the marriage of biology and psychology in the socio cultural context of the individual. The researcher recognizes that traditional African medicine is a very prominent point of entry into the socio-cultural context for many South Africans. This has already been discussed in great detail. This research endeavour aims to gain more information on depression from the perspective of the traditional healer. It therefore recognizes that in order to understand depression better, it must do so from the ‘lap’ of the traditional African healer.

In addition it seeks to shed light on some of the socio-cultural issues which may feed into a depressive episode. Furthermore it seeks to explore whether there is indeed any space in the socio-cultural context of the traditional African healer to recognize or negotiate a depressive experience.

2.5 The Traditional Health Practitioner’s Act, (Act 35 of 2004), traditional African medicine and the traditional healer

The Traditional Health Practitioner’s Act 35 of 2004 was established by the Interim Traditional Health Practitioners Council of South Africa. Its aim was to provide regulation for the safety and quality of traditional Health care services in South Africa. It also manages and controls over training and registration of traditional healers in South Africa. It provides a platform to supervise the professional conduct of services rendered. It further manages the different categories of traditional healers (Traditional Health Practitioners Act 35 of 2004).

The traditional healer practitioner is defined as one who is registered under the Act 35 of 2004, who may practice in one or more of the categories such as diviner, herbalist amongst others.

The Traditional Health Practitioners Act 35 of 2004 defines traditional health practice as the following:

‘traditional health practice’ means the performance of a function, activity, process or service based on a traditional philosophy that includes the utilisation of traditional medicine or traditional practice and which has as its object-

- (a) the maintenance or restoration of physical or mental health or function; or
- (b) the diagnosis, treatment or prevention of a physical or mental illness; or

(c) the rehabilitation of a person to enable that person to resume normal functioning
(d) the physical or mental preparation of an individual for puberty, adulthood, but excludes the professional activities of a person practising any of the professions contemplated in the Pharmacy Act, 1974 (Act No. 53 of 1974), the Health Professions Act, 1974 (Act No. 56 of 1974), the Nursing Act, 1974 (Act No. 50 of 1974), the Allied Health Professions Act, 1982 (Act No. 63 of 1982), or the Dental Technicians Act, 1979 (Act No. 19 of 1979), and any other activity not based on traditional philosophy.’

Therefore while the concepts of the supernatural and ancestry may be foreign to the westernised spectator, it is however important to note that these mystical practices are still regulated in the South African context. This ensures professional and ethical practice.

This professional and ethical practice indeed supervises the very practice of the art of traditional African healing. It goes without saying that central to all traditional healers is obviously a practice based on the principles of traditional African medicine. This aims to restore balance and healing to the body, mind and soul, by adopting the cultural values of communities. As previously reflected, the traditional healer is the primary custodian of this practice. A practice whereby the understanding of illness, as described by Pretorius (2004:533) is an ontology of disease and life, and a balance between the cosmic life forces. Pretorius (2004:533) elaborates that this life force covers the entire universe. It is believed that God is the source of this energy and regulates it. The ancestors are believed to also have access to this force. The ancestors feed important information as to how these life forces may need to be realigned.

The traditional African healer also has the means to manipulate these life forces (Pretorius, 2004:533). His/her role will emerge in response to possible disharmony between the cosmic forces, and has the esteemed role of rebalancing these life forces. However, his or her ability to do this will be dependent on the ancestors. Therefore it seems that the traditional healer has a revered role in working with great supernatural powers. These supernatural powers may be mediated by the ancestors.

2.6 The role of ancestors

Perhaps it is useful to examine in more detail the role the ancestors play in this mediation of supernatural powers. According to Campbell (1998:38) ancestors may be described as spirits similar to guardian angels. Mtshali, a Zulu traditional healer, defines the ancestors as follows: ‘ People do not actually die, they pass over then contact us. They help us. We learn that we are on earth by the will of God (Campbell, 1998:41).’

The ancestors therefore use traditional healers as instruments to manifest or make known their intentions (Campbell, 1998:41). They take on an important function in daily life. If one loses touch with the ancestors, this may impact ones luck in life (Mckay, 2010). These ‘silent and hidden ones’ (Sangoma, 2010) are believed to have both mystical powers and authority (Koptoff, 2010). The ancestors therefore play a pivotal role in notifying the traditional healer of disharmony in the environment. The traditional healer will then use this guidance to establish harmony.

Therefore communication with the ancestors is critical. Psychotropic substances may be used to induce hallucogenic states to facilitate communication with the ancestors (Hewson, 1998:1030). Alternatively, the ancestors may visit the indigenous healer in his/her dreams.

The ancestors will offer directive in terms of what must be instrumented to appease them. The ancestors may ask for ritualistic sacrifices (Louw et al., 1995:44).

As previously stated, the ancestors play the role of supporting and protecting the living from illness and harm (Crawford et al., 2004:133). If an individual neglects to fulfill rituals, this may result in an unsympathetic outcome. The ancestors may withdraw protection. Illness may be imminent (Crawford et al., 2004:133). Therefore as proposed by Maiello (2008:249) ancestry is a central cultural phenomenon in the management of illness by the African traditional healer. The traditional healer is believed to have acquired skills of practice from the ancestry (Nelms & Gorski, 2006:185). McKay (2010) boldly states that the traditional healer in a very real sense becomes the ancestor. The traditional healer only lives by the ancestors' instruction. The research has enormous respect for the importance that the ancestors play in terms of the traditional healer performing his/her duties. This appears to be paramount.

2.7 Westernized conceptions of illness vs. indigenous/traditional African conceptions of illness

In order to begin to unpack the 'nitty gritty' of an African traditional perspective of mental illness and depression, conventional and alternative traditional paradigms need to be defined. It is necessary to decipher and compare classifications between allopathic/ modern medicine and African traditional /indigenous conceptualizations of illness. While some insight has been offered with regard to African traditional medicine, it is probably best understood when compared with westernized conceptions of illness.

2.7.1 Allopathic medicine

Allopathic or modern medicine is the most pervasive medical system in western societies (Farlex, 2008). Allopathic medicine is defined as medical treatment which involves medical treatment to counter symptoms of disease (Farlex, 2008). It is causative by nature, and focuses on the individual (Gilbert et al., 2002:50). This paradigm is characterized by the testing, measurement and scientific observation of an illness (Gilbert et al., 2002:50).

This disparity between allopathic medicine and traditional African medicine is further authenticated by the fact that allopathic medicine or modern medicine generally adopts a range of specialists who may be consulted to carry out and ensure levels of wellness within their field (Vontress, 2001:92). These specialists are generally populated by medical professionals such as doctors, nurses and so on. In contrast to this, the African traditional healer singly carries out all healing interventions.

The research will be implying the above mentioned characteristics when referring to allopathic medicine. This includes referring to a model founded on scientific principles with the employment of varied specialists to perform various medical duties. The research will also uncover other characteristics of allopathic medicine by comparing it to traditional African medicine.

2.7.2 Traditional African medicine

The Traditional Healer's Practitioner's Act 35 of 2004 offers its own definition of what it terms 'African philosophy' and what it terms 'traditional philosophy' as the following:

‘indigenous African techniques, principles, theories, ideologies, beliefs, opinions and customs and uses of traditional medicines communicated from ancestors to descendants or from generations to generations, with or without written documentation, whether supported by science or not, and which are generally used in traditional health practice.’

The immediate distinction between a traditional African perspective and that of allopathic medicine is striking. This extends beyond the traditional healer being the only primary doctor. The difference is a complete philosophical shift. The very notion of soul and spirit is at the core of the African traditional healing approach. This cannot be ‘tested’, ‘measured’ or ‘scientifically observed as offered by Gilbert, et al. (1996:50)’. The research speculates that perhaps the spiritual perspective inherent in a traditional African perspective, may be viewed by allopathic frameworks as being ‘wishy washy. It may be perceived as being irrelevant to its very concrete and pragmatic approach. The colloquial term ‘chalk and cheese’ seems an apt description of the wedge between these disparate paradigms.

2.8 The body, mind and soul

Indeed, what distinguishes the ‘chalk from the cheese’, is traditional African medicine’s emphasis on soul in relation to health. Westernized approaches to health originate in the theoretical framework of Cartesian dualism which separates the mind and body (Bruce, 2002:162). Therefore the research concludes that allopathic or conventional medicine aims to restore healing to the physical body and alleviate physical suffering. In traditional African medicine, there is no divide between mind and body. This is another spiritual ingredient which is put in the melting pot of African traditional healing’s approach to illness.

Perhaps Lambo in Fernando (2003:127) summarizes some of the distinctive differences of the approach best in the following:

‘Reality in the western world has gone the way of attempting to master things: reality for the African traditional culture is found in the realm of the soul-not in the mastery of self or outer things, but in the acceptance of life of acquiescence with beings and essences on a spiritual scale... the African is the possessor of a type of knowledge that teaches that reality consists in relation not of men with things, but of men with other men, and of all men with spirits.’

The research believes that Lambo (2003) essentializes core differences between the two approaches. Traditional African medicine does not seem to adopt a westernized ‘mind over matter’ approach or a controlled achievement over things. Its approach prioritizes spiritual relationships.

The goal of a traditional African perspective is not just to alleviate the physical, but to treat the whole human being. Reality is indeed born in the realm of ‘men with other men, and of all men with spirits.’ Indeed, the traditional healing framework prides itself in holistic healing. Therefore traditional African medicine will shy away from conventional western focus on disease. Therefore the research summarizes that the African traditional approach casts a shadow on other scientific paradigms. The African traditional approach does not bask in the glory of notions of objectivity. The research concludes that illness is viewed as the end result of complex tapestry of the individual in context.

A recent study by Crawford and Lipsedge (2004:139) found that some black South Africans may have faith that biomedicine may be able to help ease symptoms. However, biomedicine may not be invested in with the same confidence to deal with the origins of illness. Therefore the treatment of the relief of symptoms may not be conceptualized necessarily as an authentic healing experience. Illness is targeted with regard to its entire relevance. Therefore belief systems and interventions are formulated around the origins, relevance and treatment of illness. This invariably will become significant in relation to body, mind and soul. The research still begs the question as to how traditional healers understand depression. Indeed the research interest will query how depression is understood or negotiated in relation to body, mind and soul.

2.9 Mental illness

Modern medicine specifically adopts the principles of psychiatry in its account of mental illness. Psychiatry is classified as a medical specialty which aims to gain research, study, prevent mental disorders (Psychiatry, 2008). The researcher will also make use of psychological findings and definitions in attempting to answer the research question. Psychology is defined as the scientific study of the mind and behaviour (Answers, 2008). It may also be referred to as the emotional and behavioural characteristics of an individual, group, or activity (Psychology, 2008). Therefore the researcher will use both psychiatric and psychological frameworks as a foundation to explore similarities and disparities between African traditional medicine and modern medicine.

A psychiatric account of mental illness may be described as ‘a medical condition that disrupts a person’s thinking, feeling, mood, ability to relate to others and daily functioning (About mental illness, 2008).’ This will invariably impact an individual’s capacity to cope with the daily demands of life (About mental illness, 2008). Modern medicine typically uses two systems to classify mental disorders (Mental disorder, 2008). This includes the International Classification of Diseases (ICD-10) produced by the World Health Organization. The other is the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) produced by the American Psychiatric Association (APA) (About mental illness, 2008). These manuals provide standardized criteria for mental disorders (Mental disorder, 2008). The criteria for depression according to the Diagnostic Statistical Manual will be discussed later. Social work has established another system called The Person in Environment System which has been developed as an alternative to The DSM-IV (Munson, 2001:37). The system is used as an optional classification system which assesses the inter relationships between clients, their systems and their environments (Corner, Nurius & Osborn, 2009:5).

These diagnostic systems may present the traditional healer with a philosophical quandary. It is therefore logical at this stage to voice an obvious question. Will these standardized categories of mental illness be understood and approved of by a traditional African healing paradigm? The protocol and diagnostic criteria outlined in westernized classification systems may be specific to modern medicine, and may be very foreign to African traditional healers’ understanding of illness and mental illness. The researcher hypothesizes that the very conceptualization of mental illness from a westernized perspective, insinuates pathology or illness. It will need to be investigated whether the traditional healers conceptualize depression in the same way. The researcher therefore by extension questions whether The Diagnostic Statistical Manual criteria would be relevant to traditional healers’ understanding of depression? This query is indeed reiterated by Kirmayer (2001:22) who suggests that psychiatry is ill suited to research cultural meanings of distress, as it reduces the complexity

of illnesses into a checklist of symptoms or signs of disorder. The researcher proposes that it is precisely in reaction to psychiatry's compartmentalization of mental illness that the person in environment system was developed by social work. It offers a holistic assessment of the person in their environment (The P.I.E System, 2010). It explores the social functioning of the client, mental health issues, physical health, environmental issues and the strengths of person in environment relationships (The P.I.E System, 2010). The researcher also embraces the person in environment approach as a much more fair psychiatric tool when working with an African client. It puts the client's psychological and psychiatric functioning in context, rather than subjecting them to westernized psychiatric assessments and diagnostic criteria.

2.9.1 The P.I.E system and traditional African medicine: implications for social work

It is not in the scope of this research to explore the P.I.E system in detail. However, the research conjectures that the P.I.E system may be a much more suitable alternative classification system. This may be used clinically in a South African context. This is precisely because it endeavours to achieve a more holistic understanding of the client. Indeed it may even offer valuable information into the world and systems of the traditional South African for patient. The researcher queries whether it could be used to gain more comprehensive insights of the depressed client in the South African context. In this way it may even offer insight into the dynamics and implications of traditional African medicine for the depressed patient in his/her context. Therefore the researcher further speculates that there may be great scope for traditional healing and social work to work together bearing the above in mind. They both prioritize the importance of working holistically with clients. This is especially essential in the area of mental health.

2.10 Normative cultural practice and mental illness

The researcher also proposes that some understanding of normative cultural practice may be needed in order to assess whether western standardized criteria are pertinent. A mental disorder or illness may also be defined as a behavioural or psychological pattern in an individual which causes distress or disability which is not part of normal development or culture (Mood disorder, 2008). It would be interesting to explore what the traditional African healer views as abnormal 'distress or disability' from a cultural perspective. In a sense this query may symbolise the crux of the research endeavour.

The researcher then surmises that the very concept of culture presents both modern medicine and traditional African medicine with an arduous task. Culture may implore both paradigms to scrutinize their subjective interpretation of what constitutes mental illness. The research speculates that modern medicine may face difficulty in trying to categorize, diagnose or recognize 'culturally relevant' depressive symptoms for an individual from a traditional African context. This is reinforced by Maiello (2008:248) who affirms that bodily descriptions may replace westernized conceptual emotional frameworks and behaviour. Therefore the researcher concludes that the cultural negotiation, presentation and understanding of distress may differ significantly. This will be discussed in more detail in the latter part of this review.

2.10.1 Diagnosis and causes

The researcher proposes that the process of diagnosis and belief in the causes of a mental illness will also be divided amongst traditional African medicine and westernized medicine.

Maiello (2008:248) affirms that indigenous medicine uses an intuitive approach. Western medicine uses an evidence based approach which separates the body and the mind. Maiello (2008:248) concludes that the two approaches can therefore not be integrated. Furthermore, the cause of mental illness will vary according to the subjective opinion of the indigenous healer (Kgaphola, 1999:30). Therefore the diagnostic interpretations offered by traditional healers may not offer a unified perspective. This may be in obvious contrast to western conceptions of illness which will be based on specific diagnostic categories.

The researcher therefore recognizes the obvious differences between traditional African medicine and westernized medicine, and their presumed diverse standpoints in understanding mental illness. Perhaps it is necessary at this juncture to explore traditional African perspectives on mental illness. This will follow in the next section of this chapter. However, the researcher proposes that social work and traditional healing share more of a common agenda in the realm of diagnosis and assessment. This may serve as a bridge between Traditional African medicine and allopathic approaches. The social context is also an area which is imperative to both. Similarly, it was also previously mentioned by Hewson (1998:1030) that traditional healers work extensively in the psychosocial context.

2.11 Traditional African understandings of mental illness

It should also be added that the very conception of what constitutes a mental illness may also vary. It may be useful at this stage, to delineate theory on traditional African medicine's perspective on mental illness. According to Ngoma, Prince and Mann (2003:353), mental illnesses are understood in the same context as general illnesses. Maiello (2008:248) reinforces this viewpoint. She affirms that body and mind are not separate. Therefore physical symptoms belong to every illness including mental illness. Consequently the very distinction between mental and physical illness may be redundant. However, there has also been some speculation as to what may be viewed as a deviation from normal mental functioning. According to Zulu Shaman, Vusamazulu Credo Mutwa (2003:22) sangomas or African traditional healers are taught how to treat mental illness. However, Mutwa mostly discusses concepts of 'madness.' The question still remains as to what constitutes this conception of 'madness' or 'mental illness.'

2.11.1 Emphasis on the supernatural

Hewson (1998:1029) outlines some of the traditional African understanding of mental illness. Hewson (1998:1029) further affirms that there may be a belief that 'mental illness' derives from psychological conflicts or disrupted social relationships which may cause imbalance. This imbalance manifests itself through mental and physical problems. Thus these psychological or spiritual factors may threaten the 'intactness of the person' (Hewson, 1999:1029). While mention is made of the psychological, mental and physical, the emphasis is generally on the supernatural and the spiritual. Furthermore, there does not appear to be specific behavioural or emotional manifestations which are regarded as diagnostic criteria. The meaning attributed to behaviour is generally attributed to bewitchment, social relationships and ancestry and may be non specific (Maiello, 2008:248). Crawford et al. (2004:133) concur that sorcery is believed to be a common cause of mental illness.

Ngubane in Eagle (2005:1999) further classifies the supernatural framework of mental illness from a traditional African perspective. The author categorizes causation as being mystical, magical or animistic. Magical refers to being in a state of pollution where one is no longer

protected from negative forces. Animistic causation occurs when one has displeased the ancestors. Magical causation is linked with witchcraft and curses. Robertson (2006:87) reflects that indigenous healers generally abide by the following diagnostic categories in their explanations of mental illness. These include the following: Ukuthwasa (calling to be a healer); Amafufanyana (possession by evil spirits) Ukuphambana (madness); Isinyama esikolweni (bewitchment at school); Ukuphaphazela (episode of fearfulness). The researcher has already discussed that Diagnostic Statistical Criteria may not fit in with traditional African perspectives of mental illness. Indeed, the researcher proposes that the Diagnostic Statistical Manual Criteria-IV R does not appear to recognize the calling to be a healer or possession by evil spirits.

Robertson (2006:88) may offer some insight on the above concern raised by the researcher. It is interesting that Robertson reports (2006:88) that Ukutshwasa, Amafufuanyana and Ukuphambana do not correspond with DSM-IV R criteria. They may therefore be referred to as culture-bound syndromes. Robertson (2006:88) reflects that what is important to recognize is that the DSM-IV R will categorize behaviours phenomenologically, while indigenous healer frameworks will rather give meaning to behaviour. Therefore there will be considerable deviation in the way mental illness will be constructed by the different paradigms.

In conclusion the researcher attests to the fact that indeed westernized conceptions of mental illness and traditional African conceptions of mental illness will vary. The researcher proposes that there may be little space by westernized approaches to make sense of spiritual or supernatural diagnostic criteria.

2.11.2 Mental illness as punishment or honorary calling

Karimi and Eschenauer (2006) explain that African communities are governed by certain code of moral ethics. These are communicated in the community through oral form such as stories and jokes. A breach of customary communal behaviour may be considered an immoral act. The community's reaction may result in deep sense of shame, guilt and a deep sense of personal failure. This in turn may result in a breakdown in mental functioning. Karimi et al. (2006) reflect that what might be commonly thought of as psychological illness may be understood by a traditional African viewpoint as being consequential of immoral behaviour. Therefore the researcher understands this to mean that an individual may suffer from a 'mental illness' if they threaten or undermine communal value systems.

Pretorious (1999:252) describes the Zulu term for the neglect of cultural practices as 'amaseko'. The individual has to own this guilt and follow through with certain rituals in order to be absolved. Therefore an episode of physiological or psychological distress may be viewed as being as a result of an immoral act. It will be interesting to observe whether the traditional healers in the sample view a depressive episode as an experience resulting from a neglect of cultural rituals or an immoral act. The researcher allows for the possibility that depression may be understood as a punishment.

On the other end of the spectrum an experience of a 'mental illness' may be viewed as a mark of respect. The Zulu Shaman, Vusamazulu Credo Mutwa does recognize that what can often look like madness or a nervous breakdown may be a calling to be a traditional healer (Mutwa, 2003:22). The research finds this illuminating. Depression in this regard becomes a

sign of honour. Once again, it will be interesting to see whether the traditional healers interviewed in this study make reference to this understanding of depression.

In summation, it appears that the traditional African healers' understanding of mental illness may potentially be related to the supernatural, a 'punishment' for immoral behaviour or a calling to be a traditional healer. Interpretations appear to be context specific and are dependent on the subjective interpretations of the African traditional healer. The question still remains as to how depression is conceived by the African traditional healer, and whether it is recognized as a mental illness.

2.12 Depression as mental illness

Depression is classified as a mental illness which is theoretically located in the domain of Modern medicine and psychology. The biomedical description of depression is described by the American Psychiatric Association as a mood disorder which involves changes in the body chemistry which in turn impacts mood and thought processes (APA, 2002). Barlow and Durand (2005:206) maintain that univocal or major depressive disorder is the most frequently diagnosed and intense experience of depression. According to the DSM IV, a major depressive disorder also referred to as a unipolar depression must occur without incidences of mania (Sadock & Sadock, 2003:534). Its biochemistry links depression to hormones and neurotransmitters. These are chemicals which regulate mood, hunger, sleep, growth and so on (Zucker, 2003:7). Low levels of serotonin and noreadrenalin are understood as being the main contributors of depression (Young, 2005:43). Other biological theories also implicate the endocrine system in the biochemistry of depression (Barlow & Durand, 2005:206).

Zucker (2003:25) proposes certain symptoms of depression which must last for over two weeks. These include: sleep disturbance; low energy and concentration; poor appetite or over eating; loss of interest in pleasurable activities; low libido; feelings of guilt and hopelessness and thoughts of death and suicide.

Beck and Alford (2006:7) similarly categorize depression as impacting the following areas namely changes in mood, poor self concept, punitive wishes and regression, vegetative signs and change in activity level. Change in mood invites increased feelings of sadness, loneliness and apathy. Poor self concept is linked to increased self reproach and self blame. Regressive and self punitive measures are linked with both the desire to escape or die. Vegetative states include lack of appetite, insomnia and loss of libido. Change in activity level includes increased agitation or retarded activity.

A combination of medical treatment and psychotherapy is often seen as a means to treat depression (Coleman and Corbitt, 2003:103). Medications used to treat depression are known as anti-depressants. These drugs regulate neurotransmitters such as serotonin, noreadrenalin, and norepinephrine. This will result in an improvement of key symptoms which are related to a depressive episode. Therefore in conclusion, it appears that according to the biomedical model there is a distinct physiology which underlines symptomatology of a depressive episode.

The researcher has established that traditional African medicine focuses more on the spiritual or supernatural components of an illness. Therefore it is presumable that this focus will not necessarily be on the physiological.

2.12.1 Depression as a psychosocial illness

Depression may also be explored from a psychosocial model. The psychological and social context of the individual may be viewed as offering significant contributing factors to the depressive state experienced (Barlow and Durand, 2005:206). It is indeed reiterated that depression cannot be addressed without addressing the context in which it manifests (Psychology Today, 2009). The social may be defined as both the physical and social environments and influences as well as structural societal elements such as class, gender and so on (Ramon and Williams, 2005:1). Harris (2001:19) cites difficulties in interpersonal relationships, finance and housing as examples of possible social stressors. Therefore the psychology or social context of the individual may need to be taken into account and explored as possible contributing factors of a depressive episode.

Interestingly enough, social work prides itself in locating illnesses in the psychological and social environments (Cowles, 2000:37). In fact social work would investigate the ripple dynamics of an illness, in this case depression in a holistic manner (Dhooper, 1997:135). The research affirms that social workers often have their fingers on the pulse of social, environmental and psychological factors related to an illness. They are therefore particularly equipped to deal with illnesses like depression. Depression is therefore seen as a psychosocial illness.

Counselling or psychotherapy is often used to deal with this aspect of depression. The social worker is also highly skilled in counselling (Dhooper, 1997:135). Psychotherapy is described as an intervention which helps clients with problems in their daily lives (Psychotherapy, 2008). It is also adopted in western frameworks as a reputable intervention in the realms of mood disorders. This may include enhancing an individual's sense of well being and working through discomfiting experiences (Psychotherapy, 2008). Therapy generally uses communication and dialogue to help the client gain insight into their current circumstances. This should hopefully result in behavioural and emotional change which aims to improve the mental health of the client and the family (Psychotherapy, 2008).

2.13 Traditional African healers working with the psychosocial context

It is undisputable that counselling is extremely valuable in assisting the client with depression. Traditional African medicine also places great worth on the counselling process. Dryden and Mylton (1999:1) maintain that exorcism, shamanism and hypnotism have a great deal in common with psychotherapy or counselling. They all include a professional relationship between an individual seeking assistance with a problem, and a trained specialist. Each of the above mentioned have their own theory on working with emotional problems, and how they should be addressed. Counselling skills are also central to the traditional healer's intervention (Sangoma, 2007).

It is often in the realm of the emotional that both paradigms will be established. Hewson (1998:1030) affirms that indigenous healers work intensively with issues that have a high emotional content or psychosocial content. Karimi in Karimi and Eschenauer (2006) confirms this in their assertion that the indigenous healer is most skilled in dealing with content that has an emotional nature.

It may further be argued that central to the therapeutic or counselling intervention is a focus on context. Psychotherapy may possibly be used to explore the contextual experience of the individual which may have resulted in distress. In other words, psychology may explore what is happening in the individual's outer circles. It should be clear, as explored above that immediate context is paramount from a traditional African perspective. Therefore although there is a notion of the individual personhood from a westernized perspective, both paradigms do place emphasis on context. However, the social worker or psychologist will explore both inter and intra personal psychology. Intra psychology means to go within the mind or psyche (Answers, 2010). The indigenous healer would look more at the inter personal and supernatural.

There are striking differences between traditional African medicine and westernized conceptualizations of depression. However they both do appear to value the emotional and psychosocial contexts.

It is presumable that the social worker or psychologist may offer a different type of counselling to the Traditional healer. (This will be discussed in the next section of this review). However, what is noteworthy is that all of the above mentioned 'gurus' alike, appear to prize a process of counselling or psychotherapy. Karmi in Karimi and Eschenauer (2006:263) indeed insists that the traditional healer is most effective in dealing with illnesses which have an emotional nature, and in this way take on a very similar role to a western counsellor.

2.13.1 The mental aspect of depression and the emphasis on spirit

It goes without saying that matters of the 'emotional', go hand in hand with matters of the mental or the mind. As previously noted by Definitions (2008), the aim of psychology is to work with the mind. Hewson (1998:1030) proposes that traditional African healing also works with the mind. The only specific point of departure is the added emphasis on the spirit. It aims to relieve impurity from the mind and body (Hewson, 1998:1030). Therefore while interventions and frameworks may be considerably different, it may be argued that both the intention of allopathic and traditional African medicine is to harmonize the body and the mind.

2.13.2 Similarities, differences and the need for cultural understanding

It is apparent that while there may be evidence for some commonality between these two schools of medicine, there are differences that do need to be acknowledged. Traditional African healers will be directive in their approach (Louw & Pretorius, 1995:50). They are a mouth piece for the ancestors who will direct the course of treatment and healing. While western psychotherapy will be more in directive, the social worker encourages the client to take responsibility for their lives (Louw & Pretorius, 1995:50). The traditional African approach may be more symbolic and intuitive, while the western approach will prioritize objectivity. As noted westernized frameworks will focus on the individual, while African conceptions will focus on the individual from a communal perspective.

The researcher therefore notes that the very conception of depression is culturally dependent. It may even be further socially constructed and open to interpretation in diverse contexts. Kirmayer (2001:23) summarizes this in the following statement, 'The perspective of clinicians is also a function of their own ethno cultural background, their training and the

context in which they work.’ There may be even more of a need to explore how different cultural paradigms may make sense of depression. According to Marsella and Yamanda in Sam and Moreira (2002), alternative cultural perspectives on mental health and illness are often left in the shade. This may be because medicine enjoys such an esteemed position. Therefore in a very real sense, the researcher is interested in a cultural interpretation of depression, as it explores the understanding of depression by traditional African healers. In order to realize this objective, the researcher will now explore cultural and modern day discourse on depression.

2.13.3 Cultural conceptualizations of depression as a clinical disorder or every day experience

Western conceptualizations of depression still appear to enjoy the most credibility amongst the paradigms. However, the perception of the meaning of depression remains diverse. Kitayama and Markus (1994) confirm that the term depression does not necessarily enjoy universal meaning, but is rather loosely referred to as an emotional experience. Interpretations of depression are dependent on social and cultural contexts. Beiser (1991:275) affirms that the term depression has not been adequately understood or agreed upon within westernized paradigms. There are therefore many contradictions in terms of a unified conception of depression as a clinical disorder. Swartz (2004:101) concurs with the above, and observes that the mere term ‘depression’ is couched in confusion. It may be understood colloquially as referring to a sad mood, rather than a clinical condition.

This idea is reinforced by Spiro in Sam and Moreira (2002) who verify that culture denotes how individuals will think and feel. Kirmayer (2001:24) explains that culture will control and make some emotions salient and others more difficult to express. It will set limits on certain feelings, sources of distress. It will also control the presence of symptomatology. Furthermore, Littlewood and Lipsedge in Swartz (2004:102) reflect that ‘precisely because sadness or happiness are everyday mechanisms, we already have available cultural mechanisms for understanding them, for modifying them and incorporating them into our social life.’ Therefore culture will dictate how sadness and other emotional experiences are negotiated (Swartz, 2004:109).

Swartz (2004) elaborates that the mere term ‘depression’ causes varied cross-cultural interpretations. It is not the intention of the researcher to make sense of this semantic muddle of colloquial and cross-cultural understandings of depression. The researcher rather aims to explore how traditional African medicine understands depression. The aim is to uncover how the traditional African healer may understand depression. The researcher will use diverse theories offered by westernized paradigms to reflect on some similarities and differences in understanding and conceptualization. However, she also makes way for the possibility that there may be no recognition of depression by the traditional African healer. There may be no clinical or colloquial everyday recognition of the term depression. Therefore the researcher’s intention is to give credence to a range of alternate cultural experiences of depression (Swartz, 2004:109) by exploring the traditional African healers’ perception of depression.

As previously stated, traditional African healers understanding of depression may not relate to clinical understandings. Indeed, clinical classifications of depression as a clinical disorder may be even more irrelevant by traditional African healers. For example one of the essential diagnostic criteria for depression is a pervasive mood of sadness (Zucker, 2003:25). Again we may need to ask how do traditional African healers’ understand or define a ‘pervasive

mood of sadness.’ Swartz (2004) queries the relevance of viewing depression as a clinical disorder by other cultural contexts. The author questions the cultural relevance of the biomedical model following DSM criteria for mood disorders.

This may be partially explained by Helman (1996:265) who explains that culture will prescribe to members, ways of becoming ill and shape what constitutes an illness and its causes. It is against this background that the research aims to explore how traditional African medicine negotiates westernized conceptualizations of illness, and mental health including depression.

2.13.4 Cross cultural understandings of depression

Some conventional understanding of depression have been challenged in order to make room for cross cultural understandings (Kirmayer, 2001:24). The masked depression hypothesis offers that in some instances an experience of depression may be valid, but not acknowledged by certain cultures (Swartz, 2004:110). These tend to be cultures more focused on the collective rather than the individual. Therefore personal or individual symptoms or experiences of distress may be ignored or denied.

Somatisation may also present as a substitute for an emotive experience of depression, sadness or distress. This is defined as a patterning of psychological disorders into verbal expressions of physical symptoms (Helman, 1996:267). Maeillo (2008:248) gives the example of how a depressed person may describe their body as being broken or broken down. This is particularly prevalent in the area of mood disorders or depression. Helman (1996:267) elaborates that diffuse and changeable symptoms may be reported such as headaches, vague aches and pains, weight loss, palpitations, loss, dizziness and fatigue. Lipsedge and Littlewood in Swartz (2004:110) affirm that depression may be misdiagnosed or missed. The relevance of somatisation may be missed or ignored by a westernized perspective.

The review will now look more closely at how culture may shape emotional experiences.

2.14 Culture and emotions

At the heart of a depressive episode is a devastating sadness. It may also be possible to describe depression as an illness which has a debilitating emotional component. This idea has been previously reflected on Zucker (2003:25) as an experience of low mood including possible feelings of guilt and hopelessness.

It is noted that culture is an important factor in the construction of an emotional experience (Emotions and Culture, 2008). This has been discussed in detail above. Once again we return to culture to gain a better understanding of how an ‘emotional’ experience of depression may be defined.

Social constructionist theories emphasize that ‘emotions are characterized by beliefs, judgments, and desires, the contents of which are not natural, but are determined by the systems of cultural belief, value and moral value of particular communities (Kleinman & Good, 1985:65). The source quoted is outdated, however the point is still just as relevant today. If depression has such debilitating emotional components, it may be interesting to explore to what extent culture shapes these primary emotional experiences. If we adopt a

social constructionist perspective, this will invariably impact a depressive experience from a traditional African point of view. This will no doubt influence how the traditional African healer will acknowledge or receive an experience of depression.

It is noteworthy that Helman (1996:265) contends that culture instructs the very language used to describe distress. Expressions of emotional distress may rely on symbols, imagery and other relevant cultural themes. The researcher will explore whether the masked depression hypothesis, somatisation and use of imagery and symbols are used by traditional African healers in their understanding of depression.

2.15 Individualistic and collective cultural emphasis on depression

The cultural mediation of emotion and indeed experiences of depression or distress will be manifold. This once again may be seen in the discrepancies between individualistic versus collective cultures. Individualistic culture may couch emotions as personal and subjective experiences. Collectivistic cultures on the other hand, may see emotions as being more objective experiences and a reflection of the outer world (Emotions and Culture, 2008). Therefore emotions become regulated experiences. Karimi and Eschenauer (2006:26) explore how emotional experiences will be defined in terms of the group. Therefore the researcher understands this to mean that emotional experiences are understood in terms of the group, rather than the individual.

Prieto and Eid (2004: 244) propose for example that an experience of emotional well being is fundamental to life fulfillment. While this may be paramount in individualistic cultures, it may be absent in other cultures. Life fulfillment may not be constructed in terms of individual achievement of emotional wellbeing. It may rather be viewed in terms of collective experience. An experience of joy may only be recognized in the realm of the interpersonal, or in the overall good for the whole (Prieto & Eid, 2004: 244). Therefore if we loosely define depression as a lack of emotional wellbeing, it may be further presumed that depression may not be afforded such interest in other cultures. Once again it is presumable that a depressive experience may be rejected. As reflected, emotions which focus on the individualistic self may be foreign. Therefore a focus on an experience of an individual's lack of emotional well being may be irrelevant.

It may even be suggested that collective cultures may place value on negative emotions (Prieto & Eid., 2004: 244). Furthermore there may be greater sanction in collective cultures in experiencing negative affect. Guilt is a commonly reinforced emotion in collectivistic cultures (Prieto et al., 2004:244). This may serve as a means to ensure that cultural and social norms are respected and reinforced. However, it is interesting to note that guilt is a common symptom of a depressive episode in western cultures (Zucker, 2003:25). Therefore a depressive experience may not be recognized as it may be seen as a bad or negative experience. It may be seen in as a natural and normal experience. Therefore there may be no meaning made of sadness or depression. This experience may not even be registered. On the other hand, as a result of the lack of sanctioning of negative emotions, there may be a reluctance to disclose these emotions.

Therefore in reference to the above, the researcher understands that the way an emotional experience of sadness or distress is regulated, may indeed have an important impact on how it is viewed or understood. This may influence whether the emotional experience is viewed as a normative or a non normative experience. All these factors will invariably shape whether

traditional African healers' view an experience of sadness or depression as an illness or not. In a very real sense, it examines the way in which traditional African healers treat or examine depression.

The point is therefore reinforced that we need to revert back to the immediate cultural context, to investigate how emotional experiences are indeed regulated or mediated. The experience of certain emotions may be more desirable than others (Prieto & Eid, 2004:244). Therefore culture will influence the intensity and frequency of certain emotions.

It may be difficult to allow for validation of an 'authentic' depressive experience. This will be moderated by culture and by certain presumptions that a depressive experience exists. This still begs the question as to what extent does traditional African culture allow for a depressive experience. It asks to what extent traditional African medicine recognizes it. There exists both overlap and contradiction in defining a depressive experience. This reinforces the researcher's intention to investigate how African culture may understand a depressive experience. This again will be investigated in the terrain of the traditional African healer.

In summation, it should be obvious that the brother and sister health paradigms of traditional versus conventional, appear unrelated. Traditional African theoretical understandings will presumably differ considerably from psychological and psychiatric insights and theories. It is in glaring contrast to allopathic medicine in its adoption of a supernatural belief system (Helman in Gilbert et al., 2002:56).

2.16 The African viewpoint of self

The distinctive philosophy on the African self intensifies the polarization of the two paradigms. In fact, the African viewpoint of self may be another important factor to consider. The next section will delve into some theoretical background on the African self. The research will 'recap' some of the theory on individualistic cultures versus collective cultures as a means of introducing theory on the African viewpoint of self.

Karimi and Eschenauer (2006) define the African viewpoint of self as 'we are therefore I am.' Mbiti (1969: 260) is quoted as saying, 'I am because we are and we are because I am.' The individualistic notion of the self as portrayed by western traditions does not exist in traditional African culture. This has been previously discussed in the exploration of individualistic versus collective cultures. Karimi and Eschenauer (2006) propose that because of it, the African healer is working from a unique standpoint. When the traditional healer is working with an individual, s/he is in fact working with an entire cosmology. The concept of the 'I' is irrelevant. An individual is granted personhood by belonging to her or his family, and the community at large. Karimi and Eschenauer (2006) insist that there is no space for the western creed of individualism. The individual has a corporate personality. This is defined by the 'other', rather than individual personhood.

Therefore it should not be surprising that from a traditional African perspective, illness may be owned or adopted by family and the community. Furthermore the treatment of mental illness may not necessarily be targeted toward the individual, but the community at large (Maeillo, 2008:248). Treatment and prevention may rely on the quality of human relationships and social interactions. Therefore it may be worth repeating, that the specific focus on the 'other' rather than the individual, is yet another distinct characteristic which

further the divide between the two paradigms. The point has indeed been exhausted that western medical discourse focuses on the individual in understanding illness and malaise. Therefore the collective needs to be considered as a potential frame of reference, when exploring an African traditional medicine perspective.

Once again this highlights an important factor in the research inquiry. It will be interesting to explore how the focus on ‘other’ rather than individual personhood may contribute to the traditional healers’ understanding of depression.

In exploring African identity, it is useful to elaborate on the individual versus collective sense of self. This has already been reflected in Prieto and Eid (2004:243) who affirm that cultures which are individualistic will prioritize emotional distance from the needs of the group. This culture will hold personal goals as primary and will negotiate behaviour according to this. However, collective cultures will prioritize the family and community needs and will aim to maintain a congruent harmony within group. Group norms in turn will further regulate behaviour and sense of self.

2.17 A closer look at African identity

It may be useful at this juncture to take a closer look at Augustine Nwoye’s (2006:) conceptualization of the African self. This may allow for more insight into the experiential and emotional factors which may contribute to the psychology of some aspect of African identity. It is not the scope of this research to unpack or delve into explorations which relate to African identity. However, it may offer more clarity into the psychosocial context which may be relevant in understanding experiences like depression. The psychological aspects, as well as cultural factors appear to be highlighted as potential contributing elements of an experience of distress. Nwoye’s (2006) analysis is obviously one sided, however, it will be interesting to see if any of these psychosocial and indeed cultural factors as discussed by Nwoye (2006), are referred to by the traditional African healer in his/ her understanding of depression. This is deemed as relevant since depression is viewed as an illness which deeply roots itself in a psychosocial context (Barlow & Durand, 2005:206). The research is of the opinion that Nwoye’s (2006) work may offer conjecture on contextual cultural influences on a depressive experience.

2.18 The physical make-up as a predisposition towards mental illness

Firstly Nwoye (2006:122) refers to the ‘embodied self’ which relates to the physicality of the individual, or ‘the body I am.’ The body itself is framed in terms of meaning and value or lack thereof. For example amongst the Zulu tradition a larger woman will be seen as a symbol of pride and respect for her husband. Physical beauty may not be seen as a blessing. It may be seen as making an individual more susceptible to vanity, which may lead to less self regulated behaviour. The possibility of promiscuous behaviour is quoted in this regard. An emphasis on the physical is important, because the body is seen as having spiritual significance. The body is further entrusted and bestowed with holding potential for good mental health. It should be noted that an undesirable embodiment is not subjectively devised, but is rather socially sanctioned by the community. Therefore the self as body, becomes imperative for good mental health in Africa.

Noles, Cash, Thomas & Winstead (2010:88) confirm that depression does distort perception of physical image. Therefore Nwoye (2006:125) affirms that the attainment of a desired

physical self may lead to a better adjusted individual- the opposite of which may exacerbate feelings of inadequacy. Once again, this may lead to an experience of distress or sadness. Nwoye (2006:125) further notes that this presents an extremely challenging experience. The physical self may be generally seen as being set in stone. Therefore the emotional or spiritual legacy coupled with it becomes irreversible. It will be interesting to explore if this cultural issue is reflected upon by the traditional healer in his or her understanding of depression.

It should be noted that the research will not specifically enquire about the possible influential aspects of the physical self on a depressive experience in the interview process. The research will only make mention of this in the analysis, should the traditional healer make direct reference to Nwoye's (2006) theory on the physical self. The research will treat Nwoye's other elaborations on the African self in a similar vein.

2.19 Genetic makeup as a predisposition to mental health

The structural self is another aspect of self which may be seen as having been inherited. The structural self includes concepts like thinking, emotions and the will. According to many African traditions, this is believed to be a genetic aspect of psychological endowment. For example an individual may be described as having a 'bad heart or 'evil eye (2006:137)'. This will in turn shape an individual's thinking, emotions and will. It may be possible to infer that a depressive disposition may also be viewed in terms of genetic endowment. It will be interesting to see if this issue is brought up by the traditional African healers in the interviews.

2.20 'Empty hand syndrome' and depression

Nwoye (2006:126) next makes mention of the 'generative self.' This refers to the enterprising aspect of the self which aims to fulfill 'personal ambitions' or an individual's plans for life. This should lead to improvement or progression of the self (Nwoye, 2006:126). The generative self may include distinctions or grading of worth. This may include for example owning land, cows, goats or sheep, financial independence, having good healthy children of both sexes, owning a house or car or having children who grow up to be respectful and successful. This aspect of self is deeply tied in with issues of status. Nwoye (2006:126) notes that many individuals may experience emotional distress as a result of 'empty hand syndrome.' This refers to the extreme poverty and social ills which have befallen many African people. This may result in extreme lack of emotional well being. Karimi and Eschenauer (2006:263) confirms that the traditional healer in trying to reach a diagnosis, may ask the patient if they do not have something they want. The research also presumes that poverty and the inability to acquire material goods may result in this type of distress. Nwoye (2006:126) affirms that a 'bankrupt generative self' may result in feelings of extreme shame, and even as a mental health illness. The individual may also continually compare his/herself with their neighbours. Nwoye (2006:127) further notes that it is interesting that many Africans have turned to church to fill this void. The church may promise that every heart desire or need will be granted and fulfilled, if faith is invested in God. This may include the attainment of jobs, children and so on.

It will be interesting to see if the 'bankrupt generative self' which may experience symptoms of an 'empty hand syndrome' will feature in the traditional healers' understanding of depression. It is presumable that the traditional healer will equate 'lack of fortune' as being invariably tied in with displeasing ancestry or in sorcery. It will be illuminating to see if this

has thematic in relevance for the traditional healers. It may also be useful to explore whether the traditional healers place personal blame on individuals for his/her misfortune. This may include for example that it may be seen as punishment for displeasing ancestors. Perhaps sorcery or muti may also be blamed for not being able to attain goods.

2.21 The melioristic self as an antidote towards depression

Nwoye (2006:135) next describes the ‘melioristic self.’ This is believed to be part of the African self which will try to make sense out of misfortune. This aspect of self is said to help the individual maintain emotional wellbeing. It is also described as helping an individual maintain a sense of hopefulness. This is believed to be an antidote to depression.

This aspect of self is constructed as the laying the foundation for good mental health. It will be noteworthy if the traditional healers refer to some of these psychological processes in his or her understanding of depression. The traditional healers may or may not view an individual’s ability to make sense of misfortune as a determinant towards an experience of distress or depression.

2.22 The narratological self as an antidote towards depression

The ‘narratological self’ is believed to be a part of self which is made up of cultural memory. This aspect of self is derived from storytelling which is used to construct a moral self. It therefore refers to the aspect of self which is embedded in cultural wisdom. This is passed on from generation to generation. This is referred to by Nwoye (2006:134) as ‘story-centered consciousness which instructs a way of behaving and negotiating life.’ Once again there is no space to allow for personal autonomy. The way one lives one’s life is negotiated from a cultural and communal authority. Nwoye (2006:134) affirms that this may indeed allow for a stern moral compass with regard to cultural heritage. However, it may induce a ‘sleep-like’ rigid doctrine ‘which may induce fear and distress. The researcher surmises that the traditional healer may value the notion of the narratological self as an antidote to a depressive experience. The richness of culture may be seen as firmly rooting the individual and providing a sense of security.

Interestingly enough, Kirmayer (2001:23) even goes as far to say that psychiatry is not suited to understand the cultural meanings made of distress, because it reduces ‘illness narratives’ to a checklist of signs and symptoms. This has been referred to previously. The research confirms that if one even views the complexity of the narratological self, one can see how indeed psychiatry may not have a broad enough framework to really understand this type of distress.

2.23 The external, cultural approval and mental health

The ‘liminal self’ reflects a part of the African self which is preoccupied with the transitional aspects of life. It requires ritual to authorize or sanction it. Nwoye (2006:137) reflects that each culture will denote specific rituals to authorize end states of transitions. The author recognizes that these transition states are often intensified by African cultures. It may be deduced that that if these transitional states are not resolved in a culturally approved manner, they may trigger extreme distress or even possible experiences of depression.

This may include for example neglecting to name a new born child in a culturally approved manner. The child may therefore not be considered a proper human being. Another example

may include the plight of parents who may only have a child of one sex. This again may not be approved of culturally. The couple may in turn be desperate to have another child of the opposite sex. It will noteworthy to see if any aspects of the liminal self are brought up by the traditional healers in the interviews.

2.24 Mystic causality and mental health

Finally, the transcendental/spiritual self may be described as a unique part of the African self (Nwoye, 2006:140). This aspect of the self reflects on God's/ ancestry's hand in orchestrating the life events for the individual. Therefore this part of the African self will view conditions/circumstances of her/his life as reciprocal as to how s/he has pleased or displeased God or ancestry. It is therefore understood that the individual will only reap the good life if s/he deserves to be a rewarded recipient. Any fortune or misfortune is consequentially viewed as an intentional act of the ancestry or God. Nwoye (2006:140) refers to this as mystic causality. Life is viewed as a continuous struggle which calls for constant intervention from a spiritual force. The research suggests that in this way the individual may on some level, be stripped of autonomy and self determination. S/he becomes dependent on other spiritual entities for a sense of well being. It could be even offered that the individual may experience a certain sense of powerlessness or distress in not having control of the process. It is interesting to note that a key aspect of depression may be an experience of not feeling in control. This of course is suggested as mere speculation. The research will see if this comes up as content in the analysis section.

The research is of the opinion that Nwoye's (2006) analysis of the African self offers a far more detailed and complex reflection on the African self. Other authors in the field appear to focus most attention to the collective aspect of self. It is apparent from Nwoye's (2006) assessment that the African concept of self is complex. His theory allows for a more in depth perspective on possible issues regarding the African self. The research once again offers Nwoye's viewpoint as a springboard to investigate what psychosocial issues are deemed as being relevant in the context of an experience of distress or depression.

2.25 Social work and mental health

Social work is defined as a 'professional activity of helping individuals, groups, or communities who enhance or restore their capacity for social functioning' (Social Work, 2008).' One of the reasons social workers are so equipped to work in the field of mental health is due to their training and sensitivity to the complexity of mental health issues. Social workers may assess psychological functioning (Over a Century of Caring, 2003). The social worker is also skilled in being able to offer assistance to individuals, groups and families, in the form of counselling, crisis intervention, advocacy and case management (Social Work Practice in Mental Health, 2010). Social workers in the mental health field are given the task of assessing and treating individuals with a mental illness or substance abuse problem (Occupational Outlook, 2008).

The researcher would at this stage also like to reflect on Zastro's (1999) insistence that the social worker should rather adopt the term 'assessment' rather than diagnosis (Turner, 2002:59). The emphasis being that assessment relies heavily on a psychosocial input. Therefore in order for the social worker to accurately 'assess' mental illness and indeed enhance 'capacity for social functioning', the social worker has to become more in touch with the distinctive traditional African presentation of depression. Indeed the social worker

cannot undertake the task of assisting individuals, groups or communities to enhance or restore their capacity for social functioning, without an understanding as to what would constitute adequate social functioning for them.

Therefore it may be argued that social workers and indeed other mental health care professionals alike, should not in good faith assess or treat individuals without an understanding of relevant influential cultural issues. This is indeed reinforced by Van Heerden and Du Preez (2002:92) in the following statement: ‘with slow persistent gruelling work from both sides, it appears far from being threatened, both can acquire new and important insights.’

Turner (2005:800) reflects that one of the greatest difficulties for the social worker is to truly understand their client. The research therefore aims to at least assist the social worker to gain a better knowledge base of systems and beliefs which may impact the depressed client. In this case, the focus is traditional African medicine and respective patients.

Once again the research proposes that these insights have invaluable implications for social work. The social worker needs information into some of the cultural African factors which may impact an understanding of depression. The social worker needs to have a better ‘grip’ of what may constitute a depressive experience in traditional African culture. The researcher hopes to start to lay the foundation for this, by gaining a better understanding of how African traditional healers understand depression.

This should enable the social worker to understand the needs of clients from their own frame of reference. This serves as a vehicle into the heart of the broader psychosocial issues related to the ‘illness.’ Cowles (2000:37) confirms that many health issues are deeply embedded in broader social and environmental issues. Depression is no exception. The social worker’s understanding of these possible factors including cultural influences is therefore essential. This is reinforced by Dhooper (1997) in Cowles (2000:37) who reflects that the social worker has the responsibility of locating the client in a holistic context. The researcher again reinstates that the cultural influence in the holistic context of depression may offer unique and valuable insights into the client.

One of the key tenets of social work is the belief in the client’s right to self determination (Holis in Sandala, 2008). This includes the client’s right to make decisions which impacts his/her life. If we adopt self determination as a core value in social work practice, we need to highlight the client’s right to choose his/her health care and belief system of choice. Therefore the social worker needs to respect the client’s adoption of traditional African medicine.

Furthermore as reflected by Dhooper (1997: 152) the social worker often takes on the role of advocate. The social worker may advocate for the rights of the client to be respected and heard. Indeed, this researcher hopes to offer a platform for a more in depth considerations of traditional African healing in the field of depression. In a sense it is also insisting that a space be made for an alternative cultural framework to be given credence. This reinforces the client’s right to self determination in the field of health care. The researcher further insists that the social worker may need to advocate this on behalf of the traditional healer in more conventional medical paradigms. Therefore a more comprehensive account of depression from a traditional African perspective will greatly assist the social worker in this regard.

Du Bois and Miley in Sandala, (2008) highlight the importance of cultural competence. This refers to an achievement of sensitivity and awareness of cultural implications and awareness in working with clients. Sandala (2008) elaborates the importance of understanding the value of communal identity in traditional societies. Therefore the researcher aims to begin to establish better cultural competence for the social worker in the field of traditional African medicine and mental health issues, such as depression.

Furthermore one of the duties of the social worker is to combat stigma (Dhooper, 1997:135). As previously explored traditional African medicine has been met with much skepticism and has indeed been looked down upon by the western world. The researcher is of the opinion that there may indeed be a great deal that traditional African healing can offer modern medicine in the field of mental illness and depression. Therefore the research has the potential to not only combat stigma, but explore possibilities of collaboration.

Kgaphola (1999:44) recognized the importance for social workers in the mental health field to regularly update themselves with latest trends, skills and the ability to work effectively with clients. Therefore the importance of further research into this particular area of mental health cannot be disputed. The social worker needs to better acquaint him/herself with the trend of traditional African healing systems in the area of depression. This should help the social worker understand the client better. This should assist in helping the client and social worker together to plan the best intervention.

2.26 Summary

In this chapter, an attempt has been made to outline key definitions and concepts in the areas of mental health and traditional African healing. This included a closer look at the traditional healer and subtypes, and the basic philosophy of traditional African healing. Care was also taken to explore the basic tenets of Allopathic medicine and traditional African medicine. The literature review also reflected on their respective approaches to mental health, and depression. Information was also provided on diagnosis, causes and categorizations of depressive experience. Cross-cultural understandings and nuances were delineated. The chapter explored issues relating to social work and mental health. Lastly, some information was offered on African identity.

Subsequently, the next chapter will focus on the research methodology and findings.

CHAPTER 3: RESEARCH METHODOLOGY AND FINDINGS

3.1 Introduction

The previous chapter has explored the reality of depression, and its significance in the South African context. Allopathic medicine's principles in relation to the 'illness' have been outlined. Care has also been taken to lay the foundation for the research to gain insight into how the traditional African healer understands depression. This has been established by underlying fundamental practices of traditional African medicine, and its viewpoint on mental illness. The previous chapter has also highlighted some literature on what would constitute a depressive experience. The passage below offers a descriptive entry into this world.

'Sometimes people with depression feel like they can't do anything. The world just grinds to a halt. All they see is endless hours. Hours of doing nothing. Hours of feeling nothing. Hours of being nobody. If this gets really bad, he might stop eating and drinking. He could even just turn his face to the wall and die... (Changing Minds, 2006).'

The time has now come to uncover whether there is indeed any scope for an understanding of depression by the traditional healer in which the 'person feels like they can't do anything.' The research indeed begs the question as to whether the traditional healer will be open to view of a depressive experience as 'the world coming to a grinding halt,' 'hours of nothing' and even 'death?' The researcher invited the traditional healer to reveal their understanding of this condition. It also allowed for consideration that the traditional healer may not grant any sanction for a depressive experience. In the following chapter, the researcher will offer these findings, and also make reference throughout on the implications this may have for social work and mental health care professionals.

3.2 Research methodology and ethical considerations

3.2.1 Research approach

Durrheim (2006:45) states that applied research has immediate practical implicit repercussions. As confirmed by Neumann (2000:23) it aims to offer information on a problem in practice. Therefore the approach is qualitative. It generated theory to be used in real life. It explored the meaning made or the understanding of depression amongst African traditional healers.

Durrheim (2006:48) proposes that qualitative research is naturalistic as it studies real people in real life situations. The subject of inquiry is how traditional healers understand depression. It is a study of a natural phenomenon in everyday life. Therefore the study is characteristic of real people in real life situations. Patton in Durrheim (2006:48) continues that qualitative research is holistic. The subject of interest is not reduced to a few clearly defined variables (Durrheim, 2006:48). It is presumable that a transcultural study requires the researcher to study a host of variables. Indeed it should be apparent now how complex it is to study the impact of culture. There are a number of variables that make up a cultural inquiry.

3.2.2 Type of research

The type of research adopted is Applied research. This research may be described as being exploratory in nature. Bless and Higson-Smith in Fouche and De Vos (2005:104) affirm that the goals of exploratory research are to gain insight into a particular phenomenon, community or

individual. Bless, Higson-Smith and Kagee (2006:46) offer that exploratory research is used to gain a broader understanding of a situation, phenomenon or person. Neuman in Fouche and De Vos (2005:104) proposes that exploratory research is always preceded by the question 'what'. Indeed the chosen research is exploratory in nature. It asks what is the traditional African healers' interpretation or recognition of depression.

3.2.3 Research design

Qualitative research is not designed by a step by step plan or recipe to follow through. Rather the research process is formulated around a research strategy or inquiry (Fouche, 2005:268).

The chosen research strategy is the case study. Creswell in (Fouche 2005:272) defines a case study as an 'exploration or in depth analysis of a bounded system...or a single or multiple case over a period of time.' Therefore what is being studied is generally a 'process, activity, event, programme, individuals or multiple individuals.' Berg (2004:251) affirms that a case study is a systematic gathering of enough information about a person, social setting, event or group to enable the researcher to understand how the subject either operates or functions. In this study the collective case study was used by the researcher to understand a social issue or population being studied (Berg, 2004:256). Therefore the researcher utilized the collective case study in order to understand how the concept of depression is received or understood in relation to traditional African healers. The researcher therefore sought to achieve an 'in depth analysis'.

Furthermore, Borg and Gall (in Berg, 2004:251) insist that the case study enables the researcher to uncover themes or patterns that other approaches may overlook. Therefore information gathered is extremely rich and detailed. The researcher therefore hoped to uncover thematic relevance of how depressive discourse is constructed by traditional African healers. This will result in an in depth analysis and also serve as a means to scrutinize current literature on the subject at hand. This objective is confirmed by Berg (2004:256) who states that multiple cases are chosen so that the comparisons can be made between cases, to enhance understanding and theory generation.

3.2.4 Description of population, sample and sampling method

3.2.4.1 Universe and population

Arkava and Lane in Strydom (2005:193) classify a universe as comprising all potential people who possess the same characteristics that the researcher is interested in. In this case, the universe may be all traditional healers in Gauteng. It would indeed be an impossible task to research an entire universe, as this would not be feasible. Therefore the researcher put certain parameters on the sample in the form of a population (Strydom, 2005:193). Bless, Higson-Smith and Kagee (2006:99) state that a population consists of the people or objects which are the focal point of the research. The researcher sets out to determine certain characteristics of the population. Babbie and Mouton (2002:173) define a population as 'the theoretically specified aggregation of study elements.' Therefore the population was traditional African healers in Johannesburg Metropolitan area.

3.2.4.2 Sampling method

Non-probability sampling was used as participants would not be randomly chosen. Berg (2004:34) classifies non-probability sampling, as sampling which is not based on a probable

outcome. Durrheim (2006:139) define this as a sample where the selection of elements are not statistically randomized. Non-probability samples according to Berg (2004:34) allows the researcher to access difficult to reach study populations. Therefore the selection could not be random, as it would be impossible for the researcher to gain access to the sample.

The snowball sampling method was used. This may be used when individuals may be hard to reach. In snowballing the researcher is able to collect information from a few subjects of the target population. These members then put him/her in contact with other members of the population (Strydom & Delpont, 2005:330). Sarantakos in Strydom and Delpont (2006:330) confirm that the process continues until there are enough respondents available to make up the sample. However, Seidman in Greeff (2006:294) also acknowledge that the researcher accumulates adequate information once the content becomes saturated. In other words, this occurs when there is a repetition of information from respondents. The researcher cannot learn anything new. Therefore although generalizability may not always be possible, the researcher can be sure that she has gathered all the necessary information.

Babbie and Mouton (2002:174) describe a sampling frame as the ‘actual list of units from which the sample is drawn.’ Bless and Mouton (2006:100) acknowledge that in order to establish a representative sample, an adequate sampling frame must be in place. The sampling frame is the traditional African healers located in Johannesburg. This will include the two interviews used in the pilot study.

The collection of the sample of ten participants from the sampling frame was administered as follows:

The researcher contacted the few traditional healers whose contact details she had already personally obtained. She then asked these traditional healers to give her contact details of other practicing traditional healers. The appointed healers were approached with a letter of informed consent, which was discussed with them. The age, gender and ethnicity of the healers were not deemed as important variables. The indigenous healers had to be African. This allowed for the presumption of a knowledge base which is centered in traditional African philosophy. While information may vary across ethnic groups, the researcher hoped to gain an overall understanding from a traditional African perspective.

3.2.5 Data collection method

The data collection method was a one-to-one interview. Berg (2004:75) defines interviewing as a conversation with the purpose to gather information. Seidman in Greeff (2005:285) affirms that the telling of stories is a way of knowing. Kvale in Greeff (2005:285) reiterates that the qualitative interview ‘attempts to understand the world from the participant’s point of view, to unfold the meaning of people’s experiences, to uncover their lived world prior to scientific explanations.’ Therefore the researcher used the one-to-one interview to understand depression from the traditional African healer’s point of view. The intention was to ‘gather information’ on how depression is understood by traditional African medicine. The interview enabled the researcher to investigate how the traditional African healer locates meaning with regard to the subject of depression.

The interview was conducted using a semi-structured interview schedule. Semi-structured interviews were used throughout the interviewing process. Berg (2004:81) argues that the semi-

structured interview allows for implementation of a certain number of pre-determined questions and topics. Greeff (2005:296) proposes that the semi-structured interview enables the researcher to obtain a detailed picture of the respondent's beliefs and perceptions about a specific topic. The researcher was able to follow up on certain avenues of interest, while the participant was at liberty to disclose as much or as little information as preferred. The researcher used open and semi-structured questions to guide the process. However, the interview schedule was used as a guide. Therefore the researcher adopted this interview process as she felt that the semi-structured interview as proposed by Greeff (2005) complements the researcher's agenda. The semi-structured interview allowed for greater leeway to explore the researcher's issues of interest. However, the participant was still in control of the process. In other words, although the researcher investigated certain relevant factors from the literature, the research content was determined by the participants. Questions were constructed so that there was an opportunity to compare traditional African conceptions with westernized theoretical viewpoints. However, there still was an opportunity for the traditional African healer to express his/her cultural viewpoint.

De Vos (2005:334) proposes that the researcher should always plan for the recording of data and use of equipment in a way which is appropriate to the settings and context. Therefore the researcher used tape recorders to record interviews. The traditional African healers did not oppose the use of technology such as tape recorders. A letter of informed consent was signed by each respondent. It was available in English, Sepedi and Zulu so that they could give written consent in their language of choice. No participants were illiterate. The information shared was kept confidential and was not used to discredit the traditional African healer.

Kelly (2006:287) also insists that the researcher should not disturb the context unnecessarily, but should try and enter in an empathic and sensitive manner (The Phenomenological...,2005). There should be an attempt made to blend in with immediate surroundings. The researcher will used directive, and tried to be as unobtrusive as possible. There was also an effort made to display a respectful demeanor. The researcher's intention was to minimize as much threat as much as possible. The researcher must also showed willingness to comply with the possibility of traditional rituals. She will follow instruction from the traditional African healer. This was be done in order to offer respect for traditional African culture.

3.2.6 Data analysis

The next phase of the research was to begin the process of analysis. Boeije (2010:94) reflects that the process of qualitative research is very simply to interpret the participant's words, try and decipher what this means and how it may be understood.' This involved using a process of coding and categorization to draw out, and group the data according to its thematic relevance. Boeije (2010:94) elaborates that the process of coding is simply 'to separate the data into meaningful parts.' In the research process, interviews were instrumented and the verbatim was used to pool together themes in order to further categorize and code the data. These categorizations highlighted key themes which comprise the research findings.

De Vos (2005:333) states that data analysis is 'the process of bringing order, structure and meaning to the mass of collected data.' Terre Blanche, Durrheim & Kelly (2006:321) propose that the goal of qualitative interpretive analysis is to provide a thick description, which means a 'thorough description of the characteristics, processes, transactions, contexts that constitute the phenomenon, couched in language not alien to the phenomenon, as well as the account of the researcher's role in constructing the phenomenon. 'Terre Blanche et al. (2006:321) elaborates that

the purpose is to put real life phenomena into some kind of perspective. Therefore the researcher will aim to achieve these objectives.

Erlandson in De Vos (2005:334) recognizes that qualitative research analysis is a two-fold process. The researcher intuitively started to analyze the data on site of the data collection. The researcher instinctively conceptualized the information shared during the interview and wrote field notes directly after the interview.

The researcher also formally analyzed the data away from the site of collection. The interviews were transcribed by researcher which helped her become more familiar with the data. Creswell in De Vos (2005:336) proposes that the qualitative researcher needs to organize the research by use of file folders, index cards and computer files. The researcher started to transform the rough data into text units.

In the next phase, the researcher aimed to immerse him/herself in the data (Kelly, 2006:288). The researcher reads and re reads the data until she or he can start to see thematic relevance. Creswell in (De Vos, 2005:337) also recommends that the researcher writes memos or notes in the margins or on the data. The researcher read the transcribed notes repeatedly. The researcher put the above mentioned into action ‘to immerse herself in the data.’

The overall intention is to step back from the data, and try to make sense of what is going on (Marshall & Rossman in De Vos, 2005:338). The researcher tries to generate themes, patterns or categories of meaning (De Vos, 2005:337). De Vos (2005:338) affirms that category generation is involved in noting similarities in texts. Therefore categorization involves differentiation between factors which are similar or dissimilar in meaning. Schatzman and Strauss in Berg (2004:276) verifies that the categories uncovered should be consistent with the research question and with the properties of the phenomenon under investigation. The intention is to make sense of the data in a way which offers insight into the ‘lessons learned’ (De Vos, 2005:338). Once again the researcher implemented the abovementioned guidelines. The researcher then generated themes and categories from the data and identified different themes.

This is followed by the process of coding the data (De Vos, 2005:338). According to Terre Blanche, Durrheim and Kelly (2006: 323), the researcher marks different sections of the data as being relevant to specific themes. Therefore certain aspects of texts are given meaningful labels or codes (Babbie & Mouton, 2002:493). Once the categories and themes are uncovered, the researcher applies a specific coding scheme and matches them throughout the data. This process may in itself generate new categories (De Vos, 2005:338). Berg (2004:269) describes this process as a ‘passport to listening to the words of the text, and understanding better the perspectives of the producer of these words.’ Babbie and Mouton (2002:494) also insist on a relational analysis where the researcher explores whether there is a positive or a negative relationship between categories. The researcher coded the data in the manner discussed above. The researcher then gave labels to different aspects in the text and related them to the themes.

De Vos (2005:338-339) stipulates that the next step involves testing emerging understandings. The researcher looked for dissimilarities and negative patterns and incorporated them into other constructs. Alternative explanations for tentative findings were investigated. The researcher also continually challenged him/herself to see if her/his deductions offer the best explanation for findings (De Vos, 2005:339). The researcher then made deductions and tried to find explanations for specific findings.

Terre Blanche et al. (2006:324) confirm that the researcher should go through the research with a fine tooth comb to elucidate the weak points. As noted by De Vos (2005:338) the researcher aims to transcribe ‘salient and grounded theories of meaning.’ However, Terre Blanche et al. (2006:323) offers that the language adopted should be drawn from the contents of the respondents, rather than theoretical abstraction. There is no recipe to follow in order to analyze qualitative research. However, the researcher used the above as guidelines in her process of data analysis. She also chose verbatim quotes from different participants to best relate to the themes found in the data.

Finally the researcher began the process of writing the report. This is a formal presentation of all the findings. Marshall and Rossman in De Vos (2005:339) suggest that in the qualitative process, the researcher has to reflect how she or he may have subjectively shaped the analytical findings. Bless et al. (2006:166) affirm that there may be a level of researcher bias where the research cannot claim to be objective, despite the best intentions. The researcher strived to be as objective as possible, and continually reflected whether her subjectivity was affecting the research outcomes.

3.2.7 Trustworthiness

The researcher took time to establish trustworthiness. This was achieved by acquiring informed consent from the sample. The researcher also answered any questions pertaining to the research and explained in detail how the interview process worked. Care was also taken to protect the sample’s confidentiality and anonymity. Identifying details and personal names were changed to ensure the privacy of the traditional healers.

The trustworthiness of the researcher needed to extend beyond care of the anonymity of the sample. The researcher also needed to ensure that the findings of the research were reflective of the traditional healers’ opinions themselves. This indeed should be the intention of any qualitative research to reflect on the sample’s viewpoint, rather than the researcher’s agenda. This was discussed briefly in the section above on data analysis. However, it still warrants further attention.

Malim (2012:3) quotes Bogdan and Biklen (1982) who confirm that qualitative research endeavours to study the subjective states of their participants. However, despite this intention this is not always so simple to accomplish. Malim (2012:1) acknowledges that the researcher’s subjectivity goes hand in hand with qualitative research. Malim (2012) elaborates that this is because the research is first negotiated by the researcher’s mind before it lands up on paper. It is therefore inevitable that there will be some level of research bias. Therefore to deal with the reality the researcher needed to continually assess research bias in her process.

In other words, the researcher also had to adopt reflexivity in research. This may be achieved by exploring the researcher’s own values in the research process (Reflexivity, 2012). Guillemin and Gillam and Reich in Lietz, Lange and Furman, (2010:447) recognize that value of reflexivity sheds light on how the researcher’s own value system may both assist and hinders the process of co-constructing meanings. Therefore the researcher took time to explore how her value system may have both assisted and hindered the process of co-constructing meaning as to how the traditional healers understood depression. The researcher has stated that the aim of the research was to give a voice to the traditional healers’ understanding of depression. The idea was to allow a stage for alternative traditional frameworks in the area of health. In a sense the research objective reflects the researcher’s own values of giving a voice to marginalized groups. This objective indeed would assist the traditional healers in the research process in a co construction of

meaning of the term depression. However, the researcher's value system may have also 'hindered' a co-construction of meaning. The researcher had to ensure that this sentiment did not cloud objectivity. The researcher tried to balance this out by stating at the onset that the traditional healer may not even accredit a construction of a depressive experience. The researcher had to bear in mind that the traditional healers interviewed may not even be interested in discussing depressive discourse. First and foremost the researcher had to inquire whether the traditional healer agreed to be interviewed on the subject of depression. The researcher also analyzed and reflected on the research process of interviewing, as a means to decipher the traditional healers' interest in depression. The pace and process of answering the questions also indicated at times that the questions on depression were not necessarily the first area of prioritized interest for some of the traditional healers. For example the taped verbatim recordings reflected gaps of silence and hesitating pauses during the research interviews. This may indicate that 'depression' is not necessarily an issue which some of the participants may not be familiar with in their practice. Of course, this is mere speculation. However, it is still taken into consideration as a possibility. This was reflected upon by the researcher in the analysis. This helped the researcher not project her agenda onto the analysis process.

One of the ways that the researcher also dealt with potential bias was the use of open ended questions in the interview process. Ronald (2011) describes the use of open ended questions as a means to combat bias in research. This is achieved because the respondents are not limited in sharing their perspectives on the subject matter. This has been discussed in previous paragraphs.

The participants were offered the service of a translator. This was also offered as a vehicle for members to truly offer their perspectives on subject matter. This was also done to ensure that data would be as authentic as possible, and also reflected cultural nuances. Above all, the researcher approached the interview process with integrity and humility. She tried to conduct the interviews in a way that would neutralize any power dynamics. Attempts were made to respect the traditional healers' level of expertise and authority throughout the interview process.

Conformability refers to the degree to which the research findings are a product of the study of inquiry or the researcher's bias (Del Siegle, 2012). The researcher attempted to ensure that the findings were more of a product of the study of inquiry. However, it is noted that some research bias was inevitable. The researcher is a white female. The interviews were conducted in English, except for one, where a translator was used. It is recognized that some information is lost by using English as a medium for communication. The traditional healers may have had to compromise the cultural content of their answers, in translating them into English. Interestingly enough, only one of the participants made use of a translator.

The research cannot claim absolute transferability. The findings may not necessarily be transferred beyond this sample. The research would need a considerably larger sample to achieve this. However, the researcher still contests that there has been effort made in trying to combat research bias. Therefore the findings and analysis may offer some knowledge in terms of how traditional healers may understand depression.

3.2.8 Pilot study

Kanjee (2006:490) affirms that a pilot study enables the researcher to test the research procedure before using it for data collection. Monette in Strydom (2005:206) offers that a pilot study is a small scale trial of all the aspects of the main study. Mitchell and Judy in Strydom (2005:206)

assess that the pilot study involves a process of ‘fine-tuning.’ It is used as a means to explore issues around the feasibility of the research.

3.2.8.1 Feasibility

According to Strydom (2005:208) feasibility refers to the actual and practical aspects of the study. The following were potential factors that could have impacted on the feasibility of the study. There may be difficulty in finding an adequate number of respondents. Therefore the predictability of an adequate sample cannot be absolutely guaranteed. If the researcher did not have a big enough sample, the research could not be continued. However, fortunately, the researcher was able to obtain a large enough sample. Therefore this issue of feasibility was accounted for.

The researcher also had to pre-empt the fact that the traditional African healers may regard the interview process as being subject to a consultation fee. This means that the researcher may have to pay for interviews from her own pocket. Therefore the potential financial expense of the research was another issue highlighted. Interestingly enough, the researcher found that the traditional healers were pleased to share their viewpoints, and did not regard the interviews as consultations.

The researcher also predicted that the gender and race of the researcher may also raise issues in terms of feasibility. This may have impacted on disclosure. There may be fear that traditional African medicine may not be understood or given due respect by a young white female researcher. This may inhibit free discussion. The researcher had to ensure that she expresses respect for traditional African medicine. She also needed to verbalize her appreciation for being in the position of learning. The researcher ensured that she did follow through on the above mentioned. This helped to harmonize potential power imbalances.

In the interviews, the traditional healers appeared to be comfortable to share openly content on their practice of traditional African healing and medicine. However, a small number of the traditional healers did confess that they could not share all relevant information regarding traditional African medicine. This appeared to be related to the fact that the information was taboo to share with outsiders. The researcher also recognizes that the sample may have withheld information due to issues pertaining to mistrust. These issues as discussed above, are potential obstacles in relation to feasibility.

It is also time consuming to gather and organize information. Time was therefore a factor that needed to be considered. Individual interviews and obtaining the sample was predicted to be time consuming.

There was no compensation for the researcher’s time and expenses. Expenses included petrol to get to traditional African healers. The researcher also had to obtain instruments to record the interviews. Traditional African healers may oppose the use of technology such as tape recorders. In this case the researcher would have to gain consent to make field notes during the interview and use a tape recorder. The researcher did gain consent in this regard. In practice, the sample was not concerned with the use of technology in the interview.

It should be mentioned that traditional African cultural discourse may not validate the reality of depression. This has been previously discussed. However, even a nullification of the reality of depression, offers rich insights. Once again this should not be viewed as a feasibility issue. The

researcher does not seek to impose westernized conceptions of depression onto traditional African healing. It aims to investigate conceptualizations of distress. This will be discussed in the section relating the findings of the research.

3.2.8.2 Testing of data collection method

A pilot study interview was conducted with two traditional healers, who did not form part of the main study to test the data collection tool. The researcher explored possible issues with regard to language. The researcher used these to uncover whether the subject of depression was a feasible topic to investigate with the traditional healers. This helped the researcher review the appropriateness of the questions in the interview and alter them accordingly. The researcher asked the traditional healer to offer input as to what questions should be asked.

The pilot study was initiated with the realization that it is not enough to prepare solely from a theoretical stance. The trial nature of the pilot study enables loose ends to be ironed out before data collection. For example, the researcher could get a real feel of the environment and possible power dynamics in practice. Certain adjustments can only be made after first-hand experience. The pilot study enabled the researcher to, metaphorically speaking, ‘get her feet wet’, and make changes accordingly. It also highlighted very real difficulties that the researcher may experience in the research process and whether these can be adequately compensated for. For example the pilot study allowed for an exploration of the willingness of traditional African healers to offer information on the subject of interest. It also provided an opportunity to explore possible language difficulties.

3.2.8.3 Ethical considerations

Ethical guidelines in research are defined as guidelines which provide standards as to how the researcher should evaluate her/his own conduct (Strydom, 2005:57). According to Strydom (2005:58) there are eight aspects of ethical protocol which need to be followed in order to achieve an ethical research outcome.

3.2.8.4 Avoidance of harm

Avoidance of harm is imperative. This implies that respondents should not be harmed in an emotional or physical manner. Non-maleficence is described by Wassenaar (2005:67) as the obligation to do no harm to respondents. There are no obvious implications in this regard to this subject of inquiry. However, the researcher made the participants feel as comfortable as possible. The researcher is well aware of the fact that she is a white female may usher in unavoidable power dynamics, as discussed above. The participants might have felt suspicious or even resentful of the researcher. Furthermore, the researcher tried to balance the dynamics by emphasizing that the participants are the experts and that they will be in the position of ‘teaching’ the researcher. These important facts are repeated in order to highlight the researcher’s intention to achieve the above mentioned objectives.

3.2.8.5 Informed consent

Informed consent is another prerequisite for ethical research (Strydom, 2005:59). Adequate information should be given regarding the goal and procedures of the investigation. The advantages and disadvantages of what the participants may be exposed to during the investigation should be uncovered. The ethical code for psychology professional code of conduct (2000) in

Babbie and Mouton (2002:536) postulates that respondents should be given ample information regarding the nature, results and conclusions of the study. Therefore the researcher offered information to the sample on the research's agenda. This view is confirmed by Williams in (Strydom, 2005:59) who states that gaining informed consent must be based on the fact that the goal and procedures used are made transparent. The researcher used a letter of informed consent to explain the purpose and process to the participants which they signed. The information shared was not be ambiguous and was also available in Sepedi and Zulu . If the participant was illiterate, consent was planned to be gained verbally. Fortunately, this did not turn out to be an issue in practice. The researcher also repeats the procedures undertaken in relation to informed consent. The researcher gained consent to tape record the interviews. The researcher made herself available to answer any queries.

3.2.8.6 Deception of subjects

Strydom (2005:60) elaborates that there should be no deception of subjects or respondents. The researcher did not deceive participants nor push her own agenda by supplementing or minimizing information offered.

3.2.8.7 Violation of privacy/anonymity/confidentiality

Strydom (2005:61) further discusses the importance that the respondent's privacy/ anonymity/ confidentiality needs to be protected. Bless et al. (2006:65) verify the need for confidentiality in research ethics. Confidentiality is described by the author as an active attempt to remove from the scripts anything that may compromise identity. Therefore the research did not disclose the identity of participants (Strydom, 2005:61). The researcher did not experience that the research process harmed any of the traditional healers in the sample. However, she did delineate the process in detail. The participants were also made aware of the nature of the research before the interview. The researcher discussed the issues in a simple manner to ensure that the information was understood. Mazabaum (2006:117) further states that the respondents should be able to withdraw at any time, and their participation should be voluntary. All information obtained was dealt with anonymously and pseudonyms were used to protect the identity of participants. Confidentiality and the participants' right to privacy were respected in this way.

3.2.8.8 Actions and competence of researchers

Strydom (2005:63) reflects that the researcher should ensure that s/he is competent enough to undertake the study. For example the researcher should be adequately skilled and should be able to exercise objectivity, and not project values. The researcher has conducted research for undergraduate studies in social work. She has obtained a Bachelors degree in Social Work, an honours degree in psychology, and completed theory module on research methodology on postgraduate level. The researcher is also registered with the South African Council for Social Service Professions.

3.2.8.9 Co operation with contributors

Strydom (2005:64) also notes that there should be cooperation with contributors to highlight agendas and reach ethical outcomes. This applies when this research is expensive and sponsor is called in for financial aid. This research did not require a sponsor and therefore the above was not applicable. However the researcher's supervisor and the researcher delineated their respective roles. The researcher made use of an interpreter where necessary. In the interview process, the

researcher only had to make use of a translator during one interview. The traditional healer concerned chose her own translator.

3.2.8.10 Release or publications of findings

Strydom (2005:65) highlights the importance of making the publication or findings public. This must be made public in a written form. As noted by Strydom (2005:65) information should be clearly formulated and expressed clearly with no ambiguity. Babbie and Mouton (2002:527) state that ethical research should make its findings available and easily accessible. The authors continue that it should be made easily available to the scientific community, so that the quality and standard of work can be assessed. Findings will also be made available to participants, as they should have primary access to results, since the research is largely a product of their making. The researcher will publish an article for a scientific journal from her dissertation and make sure that it is obtainable at the university. The researcher will share her findings where possible with the participants.

3.2.8.11 Debriefing participants

Finally Strydom (2005:66) reflects the importance of allowing for debriefing sessions. The research endeavour explores theory relating to a subject of an emotive nature. However, it may be seen as theoretical and even philosophical in nature. It does not directly ask participants to offer personal accounts of depressive experiences. Therefore debriefing participants may not be viewed as an ethical imperative. However, despite this, debriefing was done with all participants by researcher. The researcher also offered referrals for counselling, but none of the participants felt they needed it. This has already been reflected on in previous sections.

The research will now examine the relevance of the concept of depression for the traditional healers in the sample.

3.3 Research findings

3.3.1 Profile of the participants

It should be mentioned that none of the participants in the sample practiced solely as traditional healers. The primary vocation of the traditional healers was that of domestic workers, cleaners and nurses. The sample may be said to represent a sect of the opinions of the more 'urbanized' traditional healer. The participants generally worked in suburbs or private hospitals. Indeed many of the participants were surrounded by some westernized or 'urbanized' influences. Therefore different observations may have been reached if the researcher interviewed more 'rural' based traditional healers. Therefore the findings are very specific to this research.

Furthermore the research also acknowledges that the traditional healers may have chosen not to have given full disclosure to their supernatural beliefs. They may have been hesitant to share their beliefs with a white researcher. They may have been doubtful as to whether the researcher would understand or even accept their spiritual beliefs. This has already been reflected on in previous sections.

Table 1 - Biographical details of participants

Participant	Occupation	Gender	Age
Participant 1	Nurse	Female	50-60
Participant 2	Nurse	Female	50-60
Participant 3	Oral hygienist	Female	30-40
Participant 4	Nurse	Female	40-50
Participant 5	Domestic worker	Female	30-40
Participant 6	Domestic worker	Female	40-50
Participant 7	Cleaner	Female	30-40
Participant 8	Nurse	Female	50-60
Participant 9	Domestic worker	Female	50-60
Participant 10	Security guard	Male	30-40

Participant 1 is a 50 year old female nurse who works at Hospice. She confirms that she has been working at Hospice since its inception. She reported that she sees her clients for a traditional African medicine consultation outside of work. She has not shared with her workplace that she is a traditional African healer, as she believes that she may lose credibility. She trained in the rural areas. She works with divination and gives messages from ancestry to her patients.

Participant 2 is a nurse who works for a private clinic in the maternity ward. She is a middle aged woman. She trained in the rural areas. She does not confirm any specific area of expertise. She has shared with her workplace that she is a traditional healer and wears her traditional healer beads openly. She is also involved in training other traditional healers.

Participant 3 is a female oral hygienist. This is her main work. She sees her clients for her practice as a traditional healer on the side. She is around 30 years of age. She also trained in the rural areas. Her specialty is in making herbal teas which she affirms are very powerful. Her employer is aware of her vocation as a traditional healer.

Participant 4 is a female nurse between the ages of 40-50. She works as a nurse in a private clinic. She assists in the X- ray department. Her colleagues at work are aware of her vocation as a traditional healer. She sees patients privately after hours. She does not relate any specific area of expertise in relation to traditional African medicine. She also trained in the rural areas.

Participant 5 is a female domestic worker. She is 35 years of age. She trained in the rural areas. She wishes to do traditional African healing on a full time basis. However, she relies on the stable income that she receives as a domestic worker. Her present employees are not aware that she is a traditional healer. She did not complete her formal education. She mentioned that she is highly skilled in throwing the bones.

Participant 6 is a female domestic worker and is between the ages of 40-50. Her level of formal education is unknown. She trained in the rural areas. She practices openly as a traditional healer. She relates that she may even see her patients on the same premise as her employee. She does not relate any specific skill as a traditional healer.

Participant 7 works as a cleaner at a private clinic. She is between the ages of 30-40. She is not fluent in English. She trained in the rural areas. Her workplace is not aware that she is a traditional healer. She enjoys throwing the bones in practice.

Participant 8 is a nurse at a private clinic. She is in between the age of 50-60 years old. She trained in the rural areas. Her work place is aware of her vocation as a traditional healer. She confirms that even some of the doctors at her workplace will ask her opinion on some of the patients.

Participant 9 is works a domestic worker. She is between the ages of 50- 60 years old. She trained in the rural areas. Her employees are aware that she is a traditional healer. She sees clients in her room on the premises. She primarily throws the bones.

Participant 10 is a male security guard between the ages of 30-40 years old. He trained in the rural areas. His employees are not aware that he is a traditional healer. He offers that he makes very powerful muti. He believes these are more useful than western medicine.

3.3.2 Themes and sub-themes

The findings will be presented in the form of themes and sub themes. Verbatim quotes of participants from the interviews will be used to support the themes found. Literature will also be used to substantiate the themes.

3.3.2.1 Theme 1 -Relevance of the concept of depression for the traditional healer

The researcher will now explore the thematic relevance of the concept of depression for the participants.

- Sub-theme 1.1- Depression as a redundant term

The research will attempt to explore the relevance of the term depression, by first investigating how depression was at times viewed to be a redundant term by the participants.

‘Traditionally, there is not something like depression (Participant 5).’

‘Lets skip that one, I have never been depressed. I have never seen a depressed person, so there is depression, but I have never seen depressed people (Participant 3).’

‘The problem is I didn’t read it yet and depression I didn’t know... its the stress or something? (Participant 9)’

‘I think it is that you are asking...depression like it is last time, I don’t want to say the wrong thing because I don’t want to get it wrong (Participant 5).’

Trans: Okay I think that we are confused there because she answer to be a traditional healer, and then, I think that word ‘depression’ is confusing Winnie (Participant 7).’

‘Okay then in African words, we don’t have the words depression... (Participant 3).’

The literature review battled to find current research on traditional African healing and depression. This perhaps speaks to a lack of thematic relevance of depression by traditional African medicine in practice. The above statements appear to reinforce this notion that for some of the participants interviewed, ‘there is not something like a depression’. This viewpoint was

shared amongst some participants. Participant 5 became concerned as she could not properly define depression.

Participant 7's translator informed the researcher that she believed that the traditional healer was becoming 'confused' by the word depression.

Indeed, the very notion of a depressive experience seemed at times to be foreign to the participants. It appeared in some instances to be out of the participants' frame of reference. This was corroborated by one of the participants. She verified that there are no words for depression in the African language.

There were not always definitive accounts of the condition. It was explored more at times as a general condition. It was often understood more in terms of vague attributes, such as sadness. Participant 2 confirmed that she did not think that there was a difference between sadness and depression. This was reinforced at times by a lack of an experiential knowledge of depression. This is evident in the following insert from by Participant 3 when asked about how she understood depression.

'Lets skip that one, I have never been depressed, I have never seen a depressed person, so there is depression, but I have never seen depressed people (Participant 3).'

Similarly, Participant 9 confirmed that she had never had a depressed client.

'To treat them... uh uh I never seen the sadness (Participant 9).'

She reiterated that a depressed person would not need to see a traditional healer. Therefore the very relevance of the concept of depression for the traditional healer needs to be brought into question. The researcher makes room for the possibility that there may be a language issue at play. This has previously been referred to as a limitation of the research. This may impact the participant's ability to answer questions. A depressive experience may be recognised under a different African term. There may also be a lack of understanding as to what is being asked by the researcher.

The theme of depression as a 'redundant term' may also be confirmed by the manner in which the participants answered the questions. When the participants were asked questions relating to the topic, many answers appeared to require deliberation. While the participants did answer questions, the rhythm of the interview at times did not flow. It seemed as if the topic was not one that was especially familiar or immediately accessible for some of the participants.

Sub –theme 1.2- Depression as a concept ripe in relevance

The research will now further explore where depression was viewed as a concept ripe in relevance for the traditional healer. Once again, this is done in order to make sense of the overall relevance of the term depression for the participants.

'Depression is like something you can lie down into your blanket and cover you (Participant 1).'

'I am not so sure, I cannot say that it is and I can't say its not, why because you will be feeling sick inwardly, outside the flesh you will be feeling fine, but deep down in your heart, you will be feeling just down (Participant 6).'

The lack of relevance of the term depression was not unanimous amongst the sample. Some of the participants acknowledged an understanding of depression. The researcher finds the above statement by a participant a powerful description of depression. The statement may capture some of the emotional and physiological aspects of depression. This seems to tie in with Zucker's (2003:25) reflection of an experience of depression as being highlighted by feelings of hopelessness, guilt and no desire to find pleasure. Therefore it may make a person feel like lying down, and covering themselves with a blanket. Participant 6 similarly captures depression as an experience of 'feeling sick inward and feeling 'down in your heart.' Indeed this participant therefore offered a very poignant description of depression. The sample presented other insightful observations of a depressive experience.

Participant 6 offered the following account of depression.

'Yeah even internal, you know internal whereby you feel you are sick, but you can't express yourself to someone, you feel lazy, sometimes and you think maybe I am just tired and need to sleep.'

In the introduction, *Changing Minds* (2006) defined an experience of depression in which an individual feels like they can't do anything. The interview above clearly encapsulates this in a clear 'stuckness' whereby an individual cannot articulate his/her 'internal sickness', and the physical apathy of feeling 'lazy' and 'needing to sleep.' The researcher considers this to also be a good example of both Zucker's (2003:25) definition of the physiological and emotional picture of a depressive experience. It also clearly echoes an experience of an individual feeling like they can't do anything.

It will be reflected that most of the participants offered a description of some aspect of depression. Participant 8 reflected on the isolating aspects of depression.

'Depression is a sickness ... people who don't want to share, don't want to talk, people want to keep their things within themselves, and they don't want people, at the end of the day they are depressed.'

Kiehl (2005) observes a common depressive trend of the individual isolating themselves. This feeds into a vicious cycle. The author proposes that depression results in feeling the frustration of isolation which enhances the malady of being unable to reach out and communicate with others. Kiehl (2005) further compares this aspect of depression to being in an isolated room with glass windows, whereby an individual can look out and see others. However, he or she cannot connect to them. Therefore it is clear that participant 8 had insight into the isolating trends of a depressive experience. In fact, the same participant further elaborated on this:

'Sometimes other people they don't feel anything, just have nervous breakdown... when then you can get that person to find out, the person is depressed... then sometime the feeling is the person does not want to communicate with other people...always want to be by herself or himself...then you follow up, you find the person is depressed (Participant 3).'

Other common experiences associated with depression were also mentioned. Another participant referred to insomnia and nightmares. In *Depression and Insomnia* [sa] this is another common symptom associated with depression (*Depression and Insomnia*, 2010).

‘You know like the nightmares... Sometimes they don’t sleep with the nightmare (Participant 9).’

Similarly, Albrecht and Herrick (2011:28) quote insomnia as well as loss of appetite and interest in pleasurable activities as a regular complaint experienced by the depressed patient. Participant 4 above refers here to the lack of appetite, pleasure in doing things or basic motivation in accomplishing tasks.

‘I don’t want to talk to people, then you can see even the physical shape of the person, the look, the person looks withdrawn, the person looks dry, he is never washing or he has not been eating, he is also no appetite, he is losing weight, they are not interested in anything (Participant 4).’

Discussion of theme 1:

Theme 1 explored the relevancy or redundancy of depression for the participants. These findings therefore offer an understanding of depression by the participants as being at times ripe with relevance. Some of the participants achieved a very clear conceptual definition of depression, as described in the literature.

Therefore there appeared to be an argument for both the redundancy and the relevance of the term depression by the participants.

3.3.2.2 Theme 2- Conceptualization of the term Depression

This theme inquires whether the participants could account for a discrepancy between depression and sadness.

- Sub-theme 2.1-Depression constructed as an experience of sadness

It should be noted that most of the participants related to depression as an experience of sadness. One participant however, constructed it in terms of an experience of jealousy.

‘You know jealous, I can say jealous. Some people does not want person to be happy and then they making muti that he is not going to be happy. Like when I am that, I don’t want you. I don’t want someone. Then I make a muti. That someone is making a mistake in work (Participant 10).’

In this example in a jealous individual uses muti to interfere with the individual’s functioning at work. This experience of jealousy however was of course not reported by most of the participants.

Depression was for the most part related to experiences of sadness. It must be said that most of the traditional healers did distinguish between depression and sadness.

The research does, however, recognize that these concepts could not always be differentiated definitively. This is a trend which is not just specific to African culture. This is reflected upon by Swartz (2004:101) in the literature review, who concluded that there is no unified understanding of sadness and depression. Swartz (2004:101) quotes culture as being highly influential in the construction of a depressive experience. Depressive versus sad experiences are often not easily discriminated from each other. This is despite the very strong reality of a scientific paradigm in allopathic medicine, which invests in standardized measurements of behaviour or illness. Lim (2008: ix) confirms that depression is not transient sadness, but a mood disorder. Therefore these

standardized measures are not necessarily used to distinguish between ‘transient sadness’ and a mood disorder.

The traditional healers in the sample did not use standardized measures for diagnostic purposes, however, a number of the participants did allow for a discourse of depression as a more intensive sad experience. Sadness was also viewed as being short-lived, while depression was seen as having a longer duration. The following are statements from the sample which illustrate the emphasis on depression being a more severe experience of sadness, which requires a more urgent attention and intervention.

‘Ya there is when you are sad lets say someone just comes and you get sad, and then its over but with depression, you feel deep down, you will try by all ways and all means not to, but you will be feeling it (Participant 6).’

‘Sadness is something you can talk to someone...for depression you need therapy (Participant 3).’

‘Not really, but sadness does not lead you to do things like to kill yourself...don’t want to, you hate people, and meanwhile depression can cause you to take drastic actions (Participant 4).’

Therefore from the above statements, depression is differentiated from sadness in quite a few ways. It is seen as an experience which renders the individual unable to control it (Participant 6). One of the most common signs of depression is cited as being a sense of helplessness (Understanding Depression, 2010). It is constructed as condition which requires treatment such as therapy (Participant 3). Talk therapy or psychotherapy is viewed as being a key part of treating depression (Major Depression, 2010). Suicide is quoted as a defining variable (Participant 4). In All About Depression [sa] suicidal thoughts and behaviour are noted as not being uncommon in depression (Suicide and Depression, 2010).

Depression was also understood at times as being the result of harsh circumstances. (This will be explored in more detail under the theme of external variables). It was also understood as an extreme experience which had more insidious outcomes. Participant 8 recognized that sadness and depression go hand in hand. However, she cited the loss of child as an example of causing a more ‘serious’ type of sadness, which she understood as depression.

‘To my understanding there is a different, at the same it goes hand in hand, because when you are sad, you can get to an extent that you are depressed... because its not long I lost my son (Participant 8).’

Others concurred that sadness had to be present, in order for a person to become depressed. It was also impressed upon the researcher that there is a need to deal with the sadness, so that it does not lead to depression. Participant 5 recognized that depression would occur if sadness was not dealt with. She affirmed it could happen if an individual does not ‘cough out’ the sadness.

‘You can be, first of all if you are under pressure, number one you can be sad, maybe there is something that is happening in your life, which maybe you don’t like to hear that problem, so that can make you sad, you don’t cough it out (Participant 5).’

Depression is also constructed as being consequential of sadness not being dealt with.

‘You see if you don’t deal with the situation, you become depressed, you know (Participant 3).’

Discussion of theme 2:

In summation, the participants could delineate how sadness was part of a depressive experience. Interpretations of this varied. There was no common interpretation of what constitutes a depressive experience versus an experience of sadness.

3.3.2.3 Theme 3-Depression defined by participants- an ‘intuitive assessment’

The research endeavour will now draw attention to the thematic importance of the importance of the participant’s intuitive assessment of depression.

The research draws attention back to Maeillo’s (2008:248) insight that traditional healing will use an intuitive approach when assessing illness, while western medicine will use a scientific calculated approach. The research questioned the relevance of standardized measures, like the Diagnostic Statistical Manual (DSM) for the participants. Indeed the participants interviewed seemed to describe a very intuitive means of assessment of a depressive patient. Kiehl (2005) describes the use of the DSM and other such diagnostic systems as being a ‘categorization of suffering, creating a taxonomy of suffering that hopefully aids in the treatment of illness.’ Once again the researcher questions as to whether this if indeed this ‘taxonomy of symptoms’ will be useful in the traditional healers’ assessment of a depressive experience. The researcher again queries whether this type of ‘categorization’ would be constructive for the traditional healer.

The findings show that a biomedical assessment was mostly foreign to the participants. The participants generally did not rely on specific symptoms of depression, but rather used descriptive examples of what a depressed patient may look like. Therefore the participants’ definition of depression was intuitive. On the most part depression was recognized based on the subjective interpretation of the participant. This finding reflects findings by Kgaphola (1999:30) who offers that diagnosis will rely on the individual interpretation of the traditional healer. This intuitive process means that the traditional healers’ supposed diagnosis of depression again is not a checklist of symptoms. The participants used this intuitive process of diagnosis in different ways according to their practice. Many of the participants described using throwing the bones as a means to assess and therefore diagnose a depressive episode.

‘You can see but in our belief, but we used to throw bones to say that, because if she tell you that maybe she has this and this and that, so you can’t help that person because she did introduce your problem before you see it, and then if you throw the bones you can see, what problem of this and take it from there (Participant 5).’

‘Yes, I see it when I throw my bones I see it. Even when you answer me. When you talk to me...when I because I talk the bones you have to talk to me (Participant 9).’

Participant 7 described a process whereby she experiences her patient’s symptoms or feelings before they arrive.

Trans: When she wake up, she can feel it in her body there is something, and she can’t even understand, but when you arrive now she understand why she feels like this, and then she knows that it is you, you are heavy like there is something its bothering her in her body, now she knows and she understands you arrive, its this person and immediately her body is going to start to relax now, because she is going to help you.’

Participant 10 and participant 3 also reflected on similar processes.

‘Some can look by the head...like a sangoma can be dreaming. Its not a dreaming, he can just look in the eyes, but it can come like a dream and then sometime you feel like it, like you got a headache...and then you don’t allow to ask to tell me your headache. You just coming to look at something is happened to me to do with me. My headache can be like you. And then you coming to me and I can get this and this and this (Participant 10).’

‘Yes and somehow you can sense that I don’t know ... that we have a way of tapping into other people’s bodies and then you know you have a headache, then suddenly I have a headache (Participant 3).’

The ancestors are also referred to as being key in assisting the traditional healer to manage their consultation. The one participant even made reference that she had to call on the ancestors to assist her in her interview with the researcher.

‘Yes, then I say there is this person and I don’t know what it is about. Can you please come to me and help me whatever I open my mouth and then you must speak to her (Participant 9).’

‘Sometime a person comes to me with praying and after praying I talk to my ancestors... to say what is wrong with Monica. So the ancestors will tell you know this person (Participant 2).’

Therefore the point is repeated that the participants could at best offer a general description of depression. Their understanding of it appears intuitive. The traditional healer focuses on an individual assessment of each patient. The patient paints the picture for the traditional healer of their condition. The traditional healer does not rely on preconceived diagnostic criteria, or even conceptualizations of a disorder or condition. Illnesses may be patient specific.

The subjective interpretation of illness by the traditional healer was also made reference to by participant 1. The participant recognized though that each healer may have a different interpretation of illness. She however recognized that each interpretation would be valid and have something to offer the patient.

‘Like your own kids they don’t grow the same...they are growing different and they have got different gifts... its like us we have got different gifts... we can be the traditional healers like maybe five or ten... that spirit can work at the same time...and then maybe we are going to talk about you... we are five... one is going to say this way...and the other one will say the same thing I am saying, but in a different way...yours is like this and mine is like that...(Participant 1).’

Participant 9 also alluded to the fact that she can often intuitively get a sense that a client is depressed by the way in which they talk.

‘You know when they are very sad, I understand when we start talking, I know when we just start talking. Like me and you, we are not sad me and you. Yes we are just normal (Participant 9).’

Participant 10 compared his ability to understand his patient to a mother’s intuitive understanding of her child.

‘That headache can be starting at the very same time. I can look at you. Like a mom holding a baby. The baby can’t talk, but the mom can know... Something is wrong with my baby. He can touch it and then its very hot. You see and its the same for the sangoma can see what is happening (Participant 10).’

Participant 1 described how the information she received was like a poem. She described how she would get ‘one line’ at a time and need to make sense of it. It is indeed a more abstract understanding of the patient due to an intuitive process of assessment.

Discussion of theme 3:

In summation, the traditional healers’ diagnostic procedure has been established as an intuitive process. This intuitive assessment appears to be instrumented by throwing the bones; experiencing the patient’s symptoms, consulting the ancestry and getting a sense or feel from how the client talks or presents themselves.

3.3.2.4 Theme 4- Depression as an experience of ‘thinking too much’

As explored above, a universal conceptualization of depression was not necessarily reached by the participants. However, the participants highlighted some common variables or trends particular to depression. One of these factors may be described as an experience of ‘thinking too much.’

‘No I am not happy because it is not nice for a person to become depressed, sometime you can become sick...because your mind is always on that (Participant 2).’

‘Stress, you think a lot, nightmares, you know nightmare neh? (Participant 2).’

‘Thinking too much can cause depression, ya thats the main thing, thinking too much causes depression, that is what I can say (Participant 6).’

‘So I think one person gets depressed by thinking one problem over and over, without trying to solve it you know (Participant 3).’

‘You see others, they suffer if you think too much... (Participant 5).’

‘Within the human being, it build up and it grows... you know if you have got a rash, then you keep on scratching and scratching and that sore becomes bigger and bigger, so depression is like that (Participant 8).’

‘Because sometime you can be thinking too much.... But if its not bad, some people is thinking over it. If people thinking, like you if you over thinking, the head is not going to be okay (Participant 10).’

It is apparent from the above statements that many of the participants hypothesized that a depressive experience may occur if a person ‘thinks too much.’ Interestingly enough this idea is giving credence in popular culture. In Sally Barmpton’s (2009) personal memoir of depression *Shoot the Damn Dog*, she relates that people will go mad if they think too much. Cognitive Behavioural Therapy is founded on the premise that the individual needs to ‘reality test their patterns of thinking and how this impacts thinking and behaviour (Sheldon, 2011:15).’ Cognitive

distortions of a depressive episodes are discussed as being as a warped view of life being hostile (Rosensvald & Oei, 2007:57) .Therefore the theme of ‘thinking too much’ is not an unfamiliar concept to psychology in relation to depression.

In Chapter Two, the work of Nwoye (2006) on African identity was explored as to how it may influence mental health. Nwoye (2006:135) discussed the ‘melioristic self’ which is the part of self which is able to make sense of misfortune in an adaptive way. The researcher speculates that the theme of thinking ‘too much’ may indeed be symptomatic of a maladaptive melioristic self. In general the theme of ‘thinking too much’ is a trend shared amongst traditional African medicine and other psychological paradigms.

Discussion of theme 4:

In summation the idea of ‘thinking too much’ is a common variable highlighted by the participants in an experience of depression.

3.3.2.5 Theme 5- Depression as a result of external circumstances

The findings will now uncover the traditional healers’ assessment of the relevance of external circumstances in an experience of depression.

‘No no, why I disagree is that its not up in your head, its not in your mind...because lets say that you hurt me, and you don’t come back to me to fix the problem, it eats you , its eat you within you (Participant 8).’

The participants here negate the influence of internal processes like ‘thinking too much’ and rather highlight the offence that has taken place. Of course it is debatable as to whether the process of it ‘eats within you’ is actually another aspect of ‘thinking too much.’ However, it does highlight the importance of the influence of external factors in a depressive experience. Indeed, some of the traditional healers highlighted external conditions, rather than internal processes as precursors to a depressive experience.

‘Yes, like illnesses, for instance, now that the spirit is filled with HIV, most people tend to be depressed, because they don’t understand the disease and they don’t want to admit or accept the situation (Participant 4).’

‘So many things there are so many things in life, really, sometimes, you know you are married and you just get divorced, you can be depressed the whole of your life because that is something you wasn’t expecting by that time when someone is just coming and saying okay. I am divorcing you and I marrying so and so.., that is something your whole heart and that cancels your security system, you feel depressed, you feel how am I going to start a new life, thats an example whereby people get those depression things (Participant 6).’

‘To my understanding there is a different, at the same it goes hand in hand, because when you are sad, you can get to an extent that you are depressed...because its not long I lost my son (Participant 8).’

‘Sadness is when sometimes I am at home, you see and when at home... I got a husband he is living there with the children and I am here with the grandchildren... you know when I got that big one... the man like sometimes he likes to shout the children (Participant 9).’

‘You know you lose your loved one, you can become depressed... you see if you don’t deal with the situation, you become depressed, you know (Participant 3).’

The above quotes exemplify how external circumstances can induce a depression. Illness, divorce, and the loss of a child are quoted specifically. Therefore many of the participants highlighted external factors as catalysts for a depressive episode. Reactive depressions are generally described as depressions caused by unpleasant life experiences (Major Depression, 2010). ‘Situational depressions or reactive depressions are viewed as being exogenous. In FYI Living the author [sa] relates that this means that the depression occurs outside the person (Understanding Reactive Depression, 2010). Therefore the participants’ focus on external factors related to depression is another common factor that is well known to psychology.

The researcher also makes reference to Nwoye’s (2006:126) concept of the generative self. This is an aspect of African identity which aims to fulfill personal ambitions or individual plans for life. When this does not occur, it is referred to as an ‘empty hand syndrome’. Therefore the participants’ focus on external factors may also reflect on an aspect of the generative self. External factors may impact the person’s individual plans for life. This may serve as an interesting factor in relation to a depressive experience. Therefore the sample of participants recognized the important influence of external circumstances on a depressive experience.

Discussion of theme 5:

The sample of traditional healers recognized the relevance of external circumstances as significant contributing factor to a depressive experience.

3.3.2.6 Theme 6- Conceptualization of depression as illness

The researcher still questions whether depression is recognized as an illness by the traditional healers. The thematic relevance of this will now be unveiled by exploring how and whether depression was conceptualized as an illness. One of the participants was unsure if depression is an illness. This is precisely because it is not as easily recognizable as other illnesses.

‘I am not so sure, I cannot say that it is and I can’t say its not, why because you will be feeling sick inwardly, outside the flesh you will be feeling fine, but deep down in your heart, you will be feeling just down (Participant 6).’

The researcher speculates that this is the crux of why depression is indeed so difficult to recognize as an illness. As expressed by the participant above, it cannot be seen clinically. In many ways this participant’s viewpoint corroborates with current literature’s description of it as a silent disease (Healthcare, 2008). Therefore the research highlights that the traditional healers in the sample, may partly share the difficulty of conceptualizing depression as an illness. This may indeed be because it is not as observably symptomatic when compared to other illnesses.

- Sub-Theme 6.1- Depression as an illness in its own right

In some cases, depression was not recognized as an illness in its own right. It was viewed rather as a condition, which is able to precipitate other illnesses or conditions.

‘It can be an illness because if you keep it on your mind it can give you stress as an illness, and if you have stress you can have, I don’t believe it but others they say you can be affected with stroke and other kind of illness (Participant 5).’

‘She says its an illness because if you are sad most of the time its not good to your body, cause you can get something to faint and you can get ill because this thing is eating you inside (Participant 7).’

‘You can get stress up or a stroke. Something like that. The stress is causing the stroke. Sometimes you ill, you get blood pressure (Participant 9).’

Therefore the above quotes recognize depression as a condition which contributes to other illnesses or conditions. Depression was, however on occasion, recognized and conceptualized as an independent illness by other respondents. This was confirmed in the following statements.

‘Depression is the mood swings medically, which occurs when somebody has a certain problem or when you can’t deal with certain issues in life (Participant 4).’

‘It is an illness because you need to go to someone to get a help. A therapist, someone can also end up taking medicine. So it is an illness, why take medicine if you not sick (Participant 3).’

- Sub-Theme 6.2- Biomedical assumptions of what constitute illness and traditional African medicine

The researcher will now highlight whether the participants assumed biomedical discourse of what constitutes an illness. Some of the sample sanctioned depression as a legitimate illness that requires treatment or intervention. Depression was also recognized as illness, when one of the participants had a depressive experience and was hospitalized for a few days. It was in view of this, that she reconciled depression as an illness.

‘Yes, because you become sick...when you go and speak to the... when they admit you because you are sick (Participant 2).’

However, there was still no recognition by this traditional healer of a biomedical conceptualization of an illness. She explained that this is because depression is a problem of the mind. She confirmed that medical doctors could not treat depression.

‘No, because medicine cannot cure your mind (Participant 2),’

This participant quoted above, believed that a doctor’s intervention was futile. This will be further explored in the next section, regarding allopathic medicine and curing the mind. Therefore there was an inherent contradiction. While depression was at times recognized as an illness, a biomedical intervention seemed redundant. Therefore the very notion of illness, hospitalization and medication were not necessarily related. It appears that the very conceptualization of what constitutes an illness is also another ambiguous variable. This may need to be taken into consideration. Participant 10 only recognized depression as an illness on the basis of symptoms brought on by the administering of ‘muti.’

‘It depends how he mixing the thing because he not mix one thing (Participant 10).’

Therefore the presentation of depression/sadness as an illness, would be dependent on the adverse reactions caused by the muti.

Discussion of theme 6:

Therefore the researcher found that even when depression was viewed as an illness, it was not reconciled with biomedical assumptions of what constitute an illness.

3.3.2.7 Theme 7- Allopathic medicine, depression and curing the mind

The traditional healers' outlook on allopathic medicine will be explored in this theme.

- Sub- Theme 7.1- Rejection or ambivalence about allopathic treatment of depression

The findings will now draw attention to the thematic relevance of the sample's rejection or ambivalence of allopathic medicine.

It has been reflected that in some instances allopathic medicine and doctors in particular, were not esteemed with the ability to treat depression. Participants affirmed that this is because doctors cannot use medicine to cure the mind. Therefore as reflected on previously in the literature by Bruce (2002:16) the westernized medicine's prizing of Cartesian dualism is null and void. The body, mind and soul are interconnected. Westernized medicine is distrusted because it cannot cure the mind and the soul. There was also a concern that medicine could not treat illness holistically. Interestingly enough, Coady and Lehman (2010:7) describe aspects of one of the jewels of social work practice is that it focuses on the whole person and explores all physical, emotional and spiritual aspects. Therefore social work may be able to form a bridge between these two worlds. It mirrors in practice a holistic viewpoint of the individual. It also does not impose its own viewpoint on either system.

There was indeed a voiced opinion, that unlike social work, allopathic medicine would not adopt a holistic perspective. There was a concern that the spiritual aspects of the illness were not going to be addressed.

'They treat the patient with medication, but maybe they don't have enough time to look at the patient in the spiritual, physically... they only prescribe medication...but they are supposed to look at this and this and this...(Participant 1).'

Participant 1 expresses that modern medicine does not take time to explore the individual's spiritual influences. Participant 10 below reflects on the fact that modern medicine fails to incorporate the importance of culture.

'Not yet... Because is believe in western. Don't believe in culture. Tradition (Participant 10).'

This viewpoint was mirrored by participant 7. This participant also confirmed that white doctors would not be effective in treating depression, if the ancestors were punishing the patient. She implied that the patient would need to see a traditional healer to see how s/he has displeased the ancestors.

'Trans: She says that it is a punishment...Ya that is why they are not getting help from the white doctors, and that is why now you have to try another way first (Participant 7).'

Participant 10 also acknowledged that allopathic medicine would not be effective, if muti was originally used to make the person ill.

‘Good but if that thing is muti caused he not going to be alright. Because the tablets it just made that thing to sleeped, make it that thing to be drugged... Making to be drugged for a few hours and then after its starting again (Participant 10).’

In some instances the use of allopathic medicine was rejected because of the medication itself. Participant 6 implied that the patient may become addicted to the medication and that it may do more harm than good.

‘And if you don’t take it immediately then the person goes crazy, goes nuts... (Participant 6).’

Allopathic medicine was not always outright rejected, but there was not always a committed opinion as to whether medical doctors could treat depression. One of the participants affirmed that she believed that some medical doctors could treat depression, while others could not. Therefore medical doctors were not always trusted unequivocally. The lack of trust in the medical profession was compounded at times by lack of exposure. In other circumstances there was a lack of knowledge as to how doctors viewed depression.

‘I am sure they do, I cannot say they don’t because... in fact I don’t know how they feel about it (Participant 3).’

‘I don’t know (Participant 9).’

Other participants were more relaxed in their approach. Participant 5 suggested that it was irrelevant whether the patient chose a traditional healer or a medical professional.

‘Anything is just my advice if you can go to a traditional healer, and if it is not that other way, you have to go to the doctor (Participant 5).’

In summation there does appear to a sect of traditional healers who reject allopathic medicine. Others plead ignorance about an allopathic approach to treat depression. Some participants did not believe that all medical doctors could treat depression. The remaining participants were unsure as they had not been exposed to allopathic medicine.

- Sub-theme 7.2- An embrace of allopathic medicine

Ambivalence or rejection of allopathic medicine was not always a unified perception shared amongst the participants. The findings will now exemplify how allopathic medicine was at times embraced by some of the participants.

‘I would need to be truthful then I can say this, I won’t be able to help you, you need to see a medically trained somebody who is a counsellor, medically counselling, or like a psychologist (Participant 4).’

‘We don’t treat them as such. Maybe others they do, but others not, because they need doctors (Participant 5).’

Hence the above participants pointed out the thematic relevance of an embrace of allopathic medicine over traditional medicine in the treatment of depression.

Others confirmed that both modalities were effective. Madamombe (2006:11) discusses how the gulf between westernized medicine and traditional African medicine has been bridged in the last decade. Madamombe (2006) quotes WHO advocating for the incorporation of traditional healers into primary health care systems. Zavis (2000:2) confirms that medical doctors have come to appreciate the contribution made by traditional African medicine. The traditional healers' comments below appear to mirror this trend.

'Depending on how a person believes, if a person believes in a traditional healer I will be healed. Some people believe that if they go to a doctor and get tablets, they will be healed. It depends... (Participant 6).'

'Yes at the end of the day, they deal with people I deal with people...its just that there is a tablet and there is a muti, at the end of the day, you find that the same tablet is made out of the same muti, like I can say the one will be the raw way and the other one (Participant 6).'

'I will say the doctors and the traditional healers they are swimming on the same boat, let alone understanding what each other are doing (Participant 8).'

'You know what, whatever helps the patient in the end, it depends on the patient. You know someone can be depressed and go to you white people.... and then if it is a Zulu guy or someone who is very traditional, they won't go to you. They will come to me so... (Participant 3).'

Participant 3 also referred to the fact that she would first try her own treatment, but if unsuccessful, she would refer on.

'But if I see that the muti does not work I will send them for a proper consultation with a psychologist, you know (Participant 3).'

Another participant related to the fact that it was merely a practical issue which separated doctors and traditional healers working together.

'I like but how am I going to find a Dr. They are in the hospital; we are here (Participant 9).'

The above quotes seem to reflect recognition of the value of an allopathic approach. At times the traditional healers equally esteemed the modalities of traditional medicine and allopathic medicine.

Discussion of theme 7:

In summation, it appears that the sample was divided on their willingness to embrace allopathic medicine. A pocket of the traditional healers voiced a distrust of allopathic medicine, because it lacked a holistic approach. Biological assumptions as to what constitutes an illness, were also not reconciled when the traditional healer recognized depression as an illness. However, the rejection of allopathic medicine was not a unanimous opinion. Other traditional healers accredited allopathic medicine as being the only paradigm equipped to treat depression. The rest of the participants had faith that either traditional healing or allopathic medicine could treat depression.

3.3.2.8 Theme 8-The traditional healer and treatment of depression

The researcher will now relate findings of how the participants would treat depression.

‘Regarding depression, no I don’t think, I will be lying if I say as a traditional healer any traditional healer can treat depression, no accept by praying, praying to ancestors (Participant 4).’

‘You just pray for the person, and also if its somebody because he or she has come to you. You pray with the person, you teach the person this and this (Participant 4).’

Prayer is known to be an essential part of treatment by the traditional healer (De Andrade & Ross, 2005:489). Prayer and communication with ancestry were reflected as being the main medium for treatment of depression. Therefore the thematic relevance of prayer is paramount in the practice of traditional African medicine. At times prayer is viewed as the only medium that the traditional healer has at his/her disposal to treat depression. However, prayer was not the only remedy the traditional healer had in his/her tool box to treat depression. Treatment for depression appeared to be mostly medicinal. Indeed most of the traditional healers used herbs for treatment.

‘Ya, there is because normally when you are praying, or when you are working, they tell you how that person feels, that is where you know where to think which herbs can be given to that person. You can’t just take a herb, like if you have a headache you take one. You have to check first (Participant 6).’

Participant 6 here is referring to how dispensing of particular herbs is guided by the ancestors. There is also no specific muti given for depression. Interestingly enough, the same participant affirmed that herbs cannot be dispensed generally to patients who suffer from specific symptoms. She affirmed that the traditional healer would need to look at the person individually, and see what is required.

Consensus was not always reached amongst the sample with regard to muti being used to treat depression. Other participants confirmed that they could not use muti to treat depression. She explained that muti could only be used to treat illnesses of a physical nature.

‘No, I don’t think so: You don’t use muti for those things...let me explain to you.. you got a headache...like if you can take muti...something like that (Participant 9).’

‘So the ancestors will tell you this person does not need medicine. He has depression (Participant 2).’

In other cases, the participants admitted that they would be able to intervene depending on the type of depression.

‘He said in different ways. It can be that caused by in our cultures, there can be witch doctors. I don’t know if you know about that. So he explained to me that our culture is from the witchdoctors. So if it is like that we can help them, but if it is natural you go to doctors (Participant 5).’

The research understood ‘natural’ to be an experience of depression which arises in a way which is not due to the supernatural world. Faure (2002) describes that the traditional healer divides illnesses into natural and unnatural. Natural illnesses are described as illnesses caused by natural

factors such as injury, old age, or exposure to heat or cold. They may also include colds, chicken pox, mumps and so on. Unnatural causes are those which are linked to illnesses given by ancestors or spirits or illnesses. The researcher suggests that the supposed 'natural causes' of depression, may possibly even sanction biomedical discourses. This is assumed if 'natural' refers to natural processes of the body, exposure to the elements and passage of time. The traditional healer cannot therefore assist the patient, if the depression is due to these natural processes of life and being human. However, the participant in this instance, is clearly articulating that she is only equipped to treat 'unnatural' causes of depression. As previously stated, she reflects on a type of depression which has occurred as a result of ancestry and/or other supernatural influences.

In other circumstances, neither the traditional healer nor the ancestors were seen as being equipped to handle a depressive episode. In this instance neither the traditional healer's muti nor the doctor's anti depressants were viewed as adequate treatment. It is viewed here as being an illness which requires an internal psychological shift.

'and we can't help depression because the inner person will be you, you need to talk with the inner person within you and you understand yourself,, .and you ease the pain within you.. if you go to the western doctor,..they will give you depression tablets or injection.. its not going away completely.. it needs you with your inner person then you can confide the problem or identify it, then you deal with it and then you can get rid of depression (Participant 8).'

Depression is also framed in the quote above, as an experience which cannot be cured by the mere dispensing of medication. It is rather seen as something which needs to be 'owned' by the individual. The patient needs to take responsibility for his/her problems. This in itself brings symptom relief. This sentiment is echoed by Kurkus (2002) who reflects that becoming emotionally health, requires an individual to learn about the emotional self and undertake a therapeutic release of negative feelings. It may also be interesting at this point to reflect on Nwoye's (2006:135) concept of the melioristic self. This is discussed in the literature as a part of the psychological self that is able to make sense of and work through distress. The research speculates that perhaps 'owning' in emotional difficulty may help an individual strengthen the 'melioristic self.'

'Ya what I am always saying to my patient I say let nature take its course. If you give in the situation of depression, you need to do whatever your body.... you need to cry, cry... cry loud, talk to yourself, talk to yourself then you will ease the pain...you will ease the pain that is eating you... its all up to the patient (Participant 8).'

Discussion of theme 8:

In summation, the participants highlighted a range of treatments in their intervention. These included: prayer, muti, consultation with ancestry, learning about the emotional self and the expression of emotions.

3.3.2.9 Theme 9-The traditional healer as counsellor

The next section will reveal to what degree the participants prioritized counselling with regard to the treatment of depression. It will also uncover whether they would assume the role of counsellor.

‘They just need someone to talk to. Someone to trust. You know someone to open up to. Its not always about muti and throwing bones (Participant 3).’

Counselling or ‘talking’ was cited by many of the participants as being a crucial part of treatment. Cure may be described as extending beyond the dispensing of muti or ‘throwing bones.’ This viewpoint was agreed upon by many other participants in the sample.

‘If you don’t talk to people, how are you going to survive... I mean a lot is happening in this world, things have changed you know, and if you keep your problems to yourself how are you going to solve them, you need advice, you know (Participant 3).’

‘It is appropriate in the sense, that if they combine it with counselling, that they make you understand what the problem is, and as long as you as a patient who is depressed is willing to open up (Participant 4).’

‘Yes the only way you can treat people who suffer from depression is counselling...you counsel the people, and you need to make them understand its not in their head, in their mind, but its grow within the person (Participant 8).’

‘Counselling and the let the person understand the situation (Participant 7).’

‘You know what being depressed, you need treatment for it because you live in your own world, okay then and sadness is something you can talk to someone...for depression you need therapy.... I will mix some muti and talk to them. You know I spend most of my time talking to my patients, because others are not sick at all (Participant 3).’

It is of immense thematic relevance that most of the participants affirmed the necessity of some counselling in their treatment. Richter (2003:9) also emphasizes that the traditional healer may be used as a great resource as a counsellor. The quotes above undeniably illustrate that many of the traditional healers in the sample, were pleased to be a ‘great resource’ as a counsellor.

It was however, not always clear as to whether the participants would assume the role of a counsellor or refer to another professional. Some of the traditional healers recognised that counselling was out of the scope of their practice.

‘A psychologist somebody who can talk to you, a counsellor who is going to counsel you... as a traditional healer I cannot do that (Participant 4).’

‘They understand. There are psychologists. They understand because they question the illness. They want to see how much, to see the things. You know psychologists I believe they can heal the people like that (Participant 9).’

‘You see others, they suffer if you think too much we do send them to social workers for some advices and then after that they can go to the doctor (Participant 5).’

‘Counselling or ICAS... for me the ICAS, because they only talk with you (Participant 2).’

Discussion of theme 9:

It therefore appeared that counselling was viewed by many of the participants as being of great value. Some of the traditional healers confirmed that they would assume the role of counsellor, while other participants would refer to other professionals.

3.3.2.10 Theme 10-Treating body, mind and soul- depression as an experience of the supernatural, psychosocial or biochemical

The analysis will now deal with whether the participants located depression to be more of a supernatural, psychosocial or biochemical condition.

One of the most distinguishable factors between allopathic medicine and the traditional African medicine is the latter's approach to the supernatural. As previously reflected by Crawford and Lipsedge (2004:133), depression is often located in the realm of the supernatural. Therefore it was key in the research endeavour to explore whether the traditional healer understood depression as a product of supernatural influences.

The participants reflected that a belief in the supernatural world was a reality amongst many black South Africans. However, remarkably many of the participants did not seem to locate depression as a supernatural experience.

'Some people you know they just take themselves, especially you know that the black people, they say like 'mthakathi', the witch.... No no I don't believe in that thing...when I throw the bones there and start look at that person...no I just tell you whatever it is...its the bad spirit.... No you know there is the good spirit and the bad spirit...and the bad spirit you have to fight with the bad spirit...like when you pray and then you don't want the bad spirit you just want it away from you (Participant 9).'

The participant here rejects the notion of sorcery in causing depression. Therefore Crawford and Lipsedge's testimony (2004:133) to the supernatural as being a key component of a depressive experience is challenged. The above quote negates the influence of the supernatural. However, the participant does allude to good spirit and bad spiritual influences. She does not elaborate further on what this is. The researcher speculates that her reference to 'good versus bad spirit' reflects more of a superstitious belief than an actual supernatural entity. The researcher asked the traditional healer concerned if the allusion to 'these bad spirits' is more of a Christian belief based on a belief the devil. She agreed and further clarified that the 'bad spirit' does not affect health.

'Yes yes those things...yes those things we fighting with them, but not with health or like that (Participant 9).'

Barlow and Durand (2006:205) reflect that depression is a psychosocial illness. Hewson (1998:1030) is also quoted in the literature review, in saying that the traditional healer does in fact work with issues which have a high emotional content or which derive from a psychosocial context. The psychosocial context is understood very simply as that which involves the psychological and the social (Webster, 2008). The relevance of this context appeared to be adopted by many of the traditional healers interviewed. Psychosocial circumstances were often cited as a cause for depression.

'So many things there are so many things in life, really, sometimes, you know you are married and you just get divorced, you can be depressed the whole of your life because that is something you wasn't expecting by that time when someone is just coming and saying okay. I am divorcing

you and I marrying so and so... that is something your whole heart and that cancels your security system, you feel depressed, you feel how am I going to start a new life, thats an example whereby people get those depression things (Participant 6).'

'You can be sad maybe you lose someone that you are close (Participant 5).'

'Or a sad occurrence in your life, if you have lost a child you become depressed, maybe a little child, traditionally.... Yes, like illnesses, for instance, now that the spirit is filled with HIV, most people tend to be depressed (Participant 4).'

'Like someone... I can say like somebody maybe in your family, they passed away, they very ill, they very sick... that is the sadness (Participant 9).'

The relevance of the psychosocial context appears paramount. HIV and bereavement are quoted in this regard. Similarly, participant 9 specifically emphasized the fact that social relationships are often precipitating factors that may lead to a depressive experience.

'Like she says it is about community sometimes, it is about family, its not about you or me, its about the community you are in and sometimes it can be that you are not in a good relationship in the house...the community where you are staying,..ya that is the way she answered its not just your personal thing (Participant 6).'

The participants interviewed appeared leaning towards psychosocial circumstances which may be the catalyst for a depressive experience. The emphasis seemed to be more on the psychosocial than the supernatural. Therefore the psychosocial context appeared to be highly prioritized by the traditional healers. This theme was pervasive throughout most of the interviews. Only two of the participants related that depression may occur due to supernatural causes or 'natural 'causes. Participant 5 explored the possibility of witchcraft relating to a depressive episode.

'It can be that caused by in our cultures, there can be witch doctors. I don't know if you know about that'. So he explained to me that our culture is from the witchdoctors. So if it is like that we can help them, but if it is natural you go to doctors (Participant 5).'

The quote above clearly makes way for supernatural causes for depression. Participant 10 was the most insistent in the realm of the supernatural as being a significant contributing factor to a depressive episode. He emphasized the use of 'bad muti' in causing disharmony in the individual.

'And then what he did, he mixed something to make that (Participant 10).'

He also referred to unresolved conflict in families where rituals were not performed properly. This was observed to be related to discord in the afterlife.

'But they not realise... the pass away people, you see. They can be fighting. You see because of your blood (Participant 10).'

Interestingly enough, the above quotes may reflect on Nwoye's concept of the liminal self in the formation of African Identity. This is discussed in Chapter Two by Nwoye (2006:137) as the cultural ritual to authorize states of transitions and events deemed important by communal life. The author notes that the transition states are often intensified in African culture. It was explored

in the literature review that the resolution of these transitional states will offer insight into cultural factors which may cause depression or depressive states.

Discussion of theme 10:

Therefore the sample did make way for some mention of the possible involvement of the supernatural. However, emphasis on the psychosocial context appeared to have gained the most thematic relevance.

3.3.2.11 Theme 11- The spiritual significance of depression

The research will now uncover to what degree the participants recognized the possible spiritual significance of depression. In the literature review, Hewson (1999:2019) is quoted as confirming that the significance of spiritual factors is the foundation of traditional African medicine's theoretical framework on mental illness. In some of the interviews the participants concurred with the above hypothesis.

'As a traditional healer... in fact as a traditional healer we have to see what is working there in the spiritual...you cannot just have something which is there or which is not there and then you are controlled by that and spirit...there is always spirit in the patient and you as a traditional healer (Participant 1).'

'Very great, its very great because I (referring to the patient) may not believe spiritually, but there is a need a spiritual need for me to heal.. if I am not spiritually accepting what is it, or accept the spiritual talk and counselling that spiritual leaders are coming to talk to me, so that I am understanding what my problem is, I can accept the situation (Participant 4)'

The potential spiritual significance of depression was also expressed by the participant in the first interview. She viewed it as a potential experience for growth.

'Depression is like... spiritually is something that is coming to you and then it depends in the way that you believe in it...the way you take it. You may believe it and then you wait for that thing to happen...maybe it will be....its like doing a thing...obviously like under the tree there are roots and when I get under the tree there are no roots...now its starting with me.... why there are no roots...so each and everything has got its own roots... and its got its own way of growing (Participant 1).'

Participant 6 used more of Christian religious doctrine to support the possible spiritual significance of a depressive episode.

'I will take for example the story whereby Jesus is carrying the cross, he is crucified, do you think that he was not depressed by that time, when you think about it, he was depressed, but he knew what he was going through, he knew what was his aim, do you think that God was involved (Participant 6).'

Depression was also seen as being a possible outcome of not establishing a relationship with God.

'I think that if you are not in a relationship with God, and you know nothing. Or you don't believe in God. I think that it is easier for you to become depressed. If there is something, you

won't be able to kneel down, and pray... and the problem will just get worse and worse, so its very important to have that spiritual (Participant 3).'

Therefore it appears from the above participants' verbatim, that depression does offer unique spiritual opportunities. However, not all the participants concurred that the spiritual significance of depression was related to 'excavating of roots' and allowing for 'growth.' The thematic relevance of the spiritual significance of a depressive episode was not always identified or recognized as being fundamental. One of the participants recognised that a depressive experience may be necessitated by the individual needing to heal something on a spiritual level (Participant 4). However, she also stated that in other cases, a traditional healer may not be able to help him or her. She quotes that it is at times better to see a doctor. In this way, she highlights the physiological and not the spiritual significance of a depression.

'I have got this problem, this problem, I would need to be truthful then I can say this, I won't be able to help you, you need to see a medically trained somebody who is a counsellor, medically counselling, or like a psychologist, and then you know there are now counsellors that are trained to counsel people for whatever and probably the best person to talk to is a psychologist (Participant 4).'

The spiritual significance of depression, was not always accepted as 'gospel.' Not all the participants inherently recognized the spiritual significance of a depressive episode.

Participant 8 offered that depression was more of a case of an over-emotional personality variable. This was viewed as being more significant in causing a depression than any other spiritual issue.

'I am not sure, it can but it depends on the various people or a person... because if you take things too emotionally you end up depressed, and in such a way you don't get help. People who are emotionally depressed, they don't seek help, because like they have thrown the towel, they don't need anything... What they want to do they just want to die (Participant 8).'

One of the participants rejected the notion that there is any spiritual significance in being depressed. When queried as to whether she thought there was any spiritual meaning in a depressive episode, she replied:

'No I don't (Participant 9).'

Other participants saw it as a less mystical experience, or 'taking things too emotionally.' Depression was also seen as being consequential of being restricted in doing things one enjoys.

'Ya sometimes they can, actually the ancestors can make you crazy. Actually, if they don't want something they can just tell you, and you can think but I like this thing, I love this thing, but they say no don't do it (Participant 6).'

Discussion of theme 11:

In summation, the potential spiritual significance of depression was deemed great by many of the participants. Some of the participants highlighted that if one is using a traditional African healing approach, there would have to be an inherent spiritual conceptualization of a depressive experience. Others reflected that although the spiritual meaning may not be clear, it does call on

the individual to heal on some level. Various interpretations of the possible spiritual significance of a depressive episode was offered by the participants. However, other participants renounced possible spiritual interpretations. Some reflected on the need to refer a professional counsellor. Others participants focused was on individual personality variables.

3.3.2.12 Theme 12- Depersonalization of depression and punishment

The next section will uncover to what extent the participants viewed depression as a punishment or a normative experience. Nwoye (2006:140) discusses the ‘the spiritual self’ as part of African identity which makes sense of ill fortune as a sign of displeasing the ancestors. Therefore the researcher wanted to explore if the participants viewed depression as punishment from the ancestry. At times, depression was normalized as an experience which impacts all people from all walks of life. As quoted above all ‘traditional healers’, ‘professors’, and ‘lawyers’ alike will share the same vulnerability in becoming depressed. However, this was not a unanimous viewpoint.

‘You can be a traditional healer, you can be a professor, you can be a lawyer, you can be anything, but it is going to happen (Participant 1).’

‘So thats depression it happens to everybody (Participant 3).’

The above quote clearly highlights the theme of how the traditional healers ‘normalized’ a depressive experience. This is an interesting viewpoint, as it has been previously been stated that according to a traditional African medicine, mental illness may be seen as a punishment from the ancestry (Karimi & Eschenauer, 2006).

‘It (depression) is one of the things we live with and we can’t live without...Actually it depends, like I say to you before that, a person has to tell him or herself that I have to conquer this, you know... Just like you have a headache, and with this, you have to tell yourself I will be fine (Participant 6).’

Therefore depression was not viewed as a debilitating illness or a punishment, but rather an experience that simply required ‘mind over matter.’ It was viewed as a mild unpleasant physiological experience, like a headache. It is obvious here that depression is seen as an everyday part of life. Therefore in this way, depression becomes normalized. However, not all the participants viewed depression as an experience that was part of everyday life. Other participants did reinforce the viewpoint of Kirmayer and Eschenauer (2006) that a depressive experience may be a rebuke by the ancestors.

‘She says that sometimes if you have a child, and your child is having a depression, and you are taking the child to the doctor to get herbs and then she is trying another way to go to the sangoma, and then they are saying that this thing is happening from the family to the grandmother... Ya that is why they are not getting help from the white doctors, and that is why now you have to try another way first (Participant 7).’

This participant discussed how a child suffering from depression, may be a punishment for the child’s parents displeasing the ancestors. She elaborated that even ‘white men’s medicine’ would not be able to help the child. Many of the participants also related that they could be punished with a depressive experience for failing to take the call as a traditional healer. This will be

discussed in more detail in the section below. Some of the participants thought that the possibility that depression could be a punishment was absurd.

‘Sadness a punishment (laughs) a punishment from you? From the devil maybe (laughs). I don’t think so. I don’t think so. Really (Participant 9).’

‘No, nobody deserves to be punished. I am telling you, noo (Participant 3).’

Freeman, Gaety, Kupers and Fowler (2002:332) reflect that persecutory delusions often accompany distress. The researcher similarly speculates that people who suffer from depression may at times experience life as a persecutory world. They may therefore see no hope for the future. In the researcher’s clinical experience, she has observed some depressed clients feeling like ‘the world is against them.’ Therefore the social worker may be able to work alongside the traditional healer to help counsel the depressed patient. The aim would be to ease or soften the internal conflict of feeling ‘punished.’ This may help lift the depressive episode.

Discussion theme 12:

Therefore in summation, depression was at times seen as a punishment from ancestry or as being consequential of muti poisoning. However, other participants understood depression as an impersonal and normative experience.

3.3.2.13 Theme 13- Emphasis on individualistic versus collective

The research will now explore to what extent the participants reflected on depression as an individualistic emotive experience, or as a collective emotive experience. As reflected in the literature, traditional African medicine’s focus appears to be more directed on the collective wellbeing of the whole, rather than the plight of the individual. This idea was confirmed by Participant 5 when she was asked about the context of depression.

‘It can be family, it can be community as long you share a smile, the family or the community... I don’t believe that, just on your own (Participant 5).’

Therefore her proecture on the pattern of a depressive experience seems to reinforce the theme that intra psychic or merely internal psychological factors were generally not recognized. Once again we would locate this opinion to be at the heart of a traditional African medicine.

It was explored in the literature review in Emotions and Culture (2008) that individualistic cultures prioritize the personal frame of reference of an emotional experience. Collective cultures however understand emotions to be more of an objective expression of feeling. The research also understands this to mean that a collective culture will in a sense inform their members of how to define, and understand their emotive experiences in line with a collectively condoned communal experience.

Participant 9 also related to depression as being communally experienced. She related that the community may suffer a type of malaise if the traditional healer is not there to guide them with regard to proper moral behaviour. It appears that both the traditional healer’s, and the community’s emotional integrity may be threatened if the correct guidance is not given by the traditional healer. Participant 9 related her distress when her ‘son’ was sleeping on her ‘sister’s

grave. This caused tremendous upset. The correct code of proper behaviour was not being adhered to.

‘The community, you know we are just around Johannesburg we are working here, and then if you are at home you can collect the community, and sit and explain how to because in December I remember I was at home.... Ya. I clean the place. I clean the place until until. Those blankets I take them home and then I ask... and then I find out it was my son went to sleep on my grave... can you believe it, and you can’t do that. Its the bad spirit... You know you are not allowed to do that, even if you are sad. You are not allowed to do that. And then I wait and then I call him and I say to him. ‘You must not do that.’ ‘Please you are not allowed to do that.’ I never see that the grave and then somebody sleep on the top. No, you can’t do that. It’s the bad spirit (Participant 9).’

The proposal quoted Pretorius (2004:536) in his description of the traditional healer as being responsible for the community’s emotional, spiritual and cultural wellbeing. The participant above is indeed distressed, as she cannot fulfill her function in aiding the community to follow proper cultural practice. Furthermore, she also articulates that proper behaviour and display of emotions needs to be adhered to by her son. She says the following:

‘You know you are not allowed to do that, even if you are sad (Participant 9).’

Participant 10 also illustrated the influence/importance of communal ritual by collective cultures. He used an example that if a baby is not given the proper ritual of ownership by parents in its birthing. This may result in ‘fighting’ from those who have passed away, and result in extreme disharmony.

‘You can’t maybe get a work and in your head... you can’t do the right thing or the good thing. But they not realise... the pass away people, you see. They can be fighting. You see because of your blood (Participant 10).’

Therefore the collective significance of following tradition in proper ways will impact on the harmony of the community will reside. Therefore the collective experience and importance of communal health, is prioritized and will impact wellbeing. Individual psychosocial contexts are made reference to in the section above. However, it still appears that the wellbeing of the collective is also still stressed.

‘Everybody, its not necessarily a patient, with a patient, it could be because of the disease they have, and with a person it could be a happening, something that happened to you as an individual outside (Participant 4).’

‘Trans: Like she says it is about community sometimes, it is about family, its not about you or me, its about the community you are in and sometimes it can be that you are not in a good relationship in the house... the community where you are staying, ya that is the way she answered its not just your personal thing (Participant 7).’

Many of the participants recognized the possibility that depression may occur both within the community or the individual.

‘The patient, other people, your children, your family (Participant 2).’

‘Sometimes it can be the patient, sometimes it can be the family more than the patient (Participant 1).’

Discussion of theme 13:

Therefore in summation, the participants appeared to express that they may recognize depression as both an individualistic and collective emotional experience.

3.3.2.14 Theme 14-The depressing job of being a traditional healer

The next section will explore the how the participants reflected on the distressing and even depressing aspects involved in being a traditional healer. The participants’ understanding of depression was at times very specific to personal experiences of depression.

‘Ya, I want to make an example about you...on March my husband run away he leave me with kids, he didn’t support us he didn’t, come to us, no contact, no nothing... so this thing it was always on my mind, I didn’t know...when I work I feel like crying because every now and then I think of that... I have to sleep in hospital (Participant 2).’

The participant quoted above went onto describe her assessment of being treated allopathically for her depression. However, it will be offered that most of the accounts of depression appear to be related very specifically to the job of traditional healing. Many of the participants discussed how depression may be inflicted on the traditional healer for neglecting to take the call to be a traditional healer. It was mentioned in Chapter Two that a nervous breakdown may actually be a calling to be a traditional healer (Mutwa, 2003:22).

‘Ya, they are punishing you, you don’t want to do your job..... Yes, say for instance they to tell you what they want you to do...to be a sangoma and you don’t want to be a sangoma, you keep on running, keep on running (Participant 3).’

Howles (2008) reflects that there are great emotional tolls in working as a therapist. Cherry (2010) affirms the above in her assessment that the job of being a therapist is emotionally exhausting. It was explored in the previous sections, that the traditional healer often wears the hat of a counsellor or therapist. Therefore the job of being a traditional healer may therefore indeed be ‘emotionally taxing’ or ‘exhausting.’

Many of the participants discussed depression as being part and parcel of the job of being a traditional healer. It may be offered that the traditional healer has to deal with additional difficult components, which may be seen as being ‘emotionally taxing.’ One of the participants reviewed how she becomes depressed when bad news/prophecies are relayed to them. Depression is constructed here, not so much as a reprimand from ancestry. It is rather seen as being part of the trauma in the anticipation of bad prophecies.

‘Depression, I understand depression by the ancestors, the ancestors... sometimes you feel you are going to hear something bad... and that thing depresses you (Participant 3).’

‘You know to be a traditional healer is a very hard thing... Like as you think? because you can’t understand like sometime you are starting to be sick. Sometime its coming with the dream. You see and then you don’t understand (Participant 10).’

The job of traditional healing is indeed emotionally taxing in many other regards. Another participant reflected on the difficulties of seeing someone who is depressed.

‘No I am not happy because it is not nice for a person to become depressed, sometimes you can become sick...because your mind is always on that (Participant 2).’

‘Everybody you know, you know what, I think that I am going to get depressed, I have a patient of mine(laughs), she is just too much for me (laughs) I can’t handle her... she is going to depress me (Participant 3).’

One of the participants reported the antithesis of this.

‘Okay not not in my ancestors, no I don’t stress (Participant 9).’

However, it does appear that the job of being a traditional healer may burden the traditional healer with some emotional challenges.

Furthermore participant 3 discussed the difficulty of working as traditional healer and still participating in a secular world.

‘I am both what living in urban and civilized worlds, I can be depressed. I can be depressed in having two different jobs (Participant 3).’

Discussion of theme 14:

In summation the participants appeared to be commenting on how various depressing dilemmas may confront the traditional healer in his/her line of work. Depressive experiences may be consequential of neglecting the ‘call’ to take on the vocation of a traditional healer. Depression or distress was also related to the participant feeling traumatized in relating troublesome prophecies to patients.

3.3.2.15 Theme 15- Somatisation

The next section will unveil the thematic relevance of somatisation relayed by the participants. Mosby’s (2008) medical dictionary describes somatisation as a process ‘whereby a mental event is expressed as a bodily or physical symptom (The Free Dictionary).’

As previously described Maeillo (2008:248) affirms that bodily descriptions may replace what is seen as westernized conceptual emotional frameworks. Somatisation was not a theme predominantly described by the participants. The researcher also proposes that due to the holistic nature of traditional healing, the physical and psychological would present as the same symptom. Therefore it may be a very challenging area to explore. It may be ultimately argued that a traditional healer would very much understand the physical from a broader context, and therefore inherently endorse a concept of somatisation.

Interestingly enough, when participant 10 was asked about sadness/depression, he went into a detailed discussion on headaches. This may represent a process where the experience of depression becomes a physical symptom. This point is reinforced by the participant below. He said the following when asked about depression.

‘Yes, that cause you some paining, headache, neck, whatever... (Participant 10).’

Depression may be associated with physical pains like a headache (Depression and Headaches, 2008). However, the research also makes way for the possibility that this participant went on to discuss headaches as the concept of sadness/depression was not relevant for him/her.

‘First they come to you and if they want to consult, they consult...throw the bones and then there is just that asking questions. Sometimes they keep quiet. So...this is what is happened in your life, this and this and this. Then they will just keep quiet. So you need to come back. You need to comfort them. You need to reassure them until they open up. Thats the only way. Then you can start, giving them whatever muti you give (Participant 3).’

Discussion of theme 15:

Therefore the concept of somatisation was not heavily reflected on by the traditional healers. However, the relevance of somatisation should not be dismissed. This will be further discussed in more detail in the conclusions.

3.4 SUMMARY

The chapter explored the findings of the research in terms of their thematic relevance. The findings firstly explored the relevance of the concept of the depression. It was concluded that depression maintained both relevance and redundancy. Interestingly enough, many of the traditional healers achieved a conceptual understanding of depression. The second theme reflected on the conceptualization of depression as more of an intense experience of sadness. However, the differences between depression and sadness could not be accounted for definitively. The third theme explored how traditional healers use an intuitive assessment process in recognizing depression. There were no unified accounts offered of depression. The fourth theme spoke to how the traditional healers confirmed that a common cognitive dysfunction of ‘thinking too much’ is often present in a depressive experience. External circumstances were also noted as a contributing factors to a depression in fifth theme. Theme 6 investigated to what extent depression is constructed as an illness. Depression was not identified as an independent illness. It was rather seen as aggravating other medical conditions. At times depression was appreciated as being an illness. However, bio medical interventions were not necessarily approved of. Allopathic medicine was received with mixed reviews in treating depression in Theme 7. Theme 8 highlighted the broad range of treatment that may be adopted by the traditional healer in treating depression. This included the use of muti, ancestry, prayer, learning about the emotional self and expressing emotions. The importance of counselling was reflected on in Theme 9. Some of the counsellors would adopt this role, while others would refer to other professionals. Theme 10 reported that depression would inherently be seen from a supernatural perspective. This may be despite the fact that depression was also seen as having fundamental psychosocial influences. The potential spiritual significance of depression was discussed in Theme 11. There was however no consensus as to whether all depressive experiences were spiritually significant. Theme 12 identified that depression could be both viewed as an impersonal and normative experience, as well as a punishment from ancestry or the result of muti poisoning. Depression was situated somewhere on the continuum of individualistic and collective cultures in Theme 13. Theme 14 affirmed the thematic relevance of depression or distress for the traditional healer in her/his vocation as traditional healer. Finally Theme 15 confirmed a lack of thematic relevance in terms of somatisation and depression for most of the sample. The following chapter will include the summary, conclusions and recommendations.

CHAPTER 4 -SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

4.1 Introduction

In this chapter a summary of the research will be presented. The focus will be on how the aims and objectives of the study were achieved. It will also be shown how the posed research question was answered. The research will also expand conclusions reached. Lastly the research will focus on recommendations for culturally sensitized practice. Recommendations for future research will also be offered.

4.2. Objectives

Subsequently each objective will be discussed in terms of how it was met in this study:

-To conceptualize mental health and depression and the treatment of depression from both a westernized and an African traditional paradigm.

This objective was accomplished by conducting a literature review on depression and how it is conceptualized from both a westernized and traditional African paradigm. These conceptualizations were presented in Chapter Two. The literature review explored background information on key concepts related to the traditional African healer, traditional African medicine, and allopathic medicine. Care was taken to outline both paradigms' approaches to mental illness and depression. The research also explored how depression may be recognized as a mental illness and a psychosocial illness. The literature review also reviewed cultural conceptualizations of depression. This included exploring traditional African medicine's emphasis on the supernatural in relation to understanding illness and mental illness. There was also mention made of culture and emotions. Some information was also offered on how individualistic versus collective cultures may differ in regulating emotional experiences. Lastly a brief look at the African viewpoint of self was offered. This was explored as a means to further investigate how it may relate to depressive experiences.

-To explore how 'depression' is understood and treated by African traditional healers.

This objective was achieved by means of the empirical research. The researcher aimed to achieve this objective by using semi structured interviews and inquiring from the participants how they understood or conceptualized depression. The research endeavour aimed to explore how the sample recognized depression. The research inquired as to whether specific symptoms were reported. The research also highlighted different opinions and conceptualizations of depression amongst the participants in the sample. Reference was also made to what participants considered to be appropriate treatment. Reflections were made as to whether the participants believed depression could be treated. Distinctions were made as to whether the participants affirmed that they could treat a depressive patient or whether referrals to other mental health care professionals were deemed appropriate. Finally the research also gave an account as to whether understandings of depression were related to traditional African cultural characteristics. The research also explored whether the traditional African medicine healers' understandings of depression were related to Allopathic medicine principles.

-To provide insight into relevant contextual cultural issues for social workers and other mental health care providers, when working with persons from the African cultural context so as to render culturally appropriate intervention

This objective was also achieved again by means of the empirical research. The data collected themes on culturally relevant issues raised by the participants. The participants were asked to discuss aspects relating to depression from their traditional African point of view. These included: relevancy of depression; distinctions between depression and sadness; intuitive assessments of depression; external circumstances; psycho social circumstances; relevance of biomedical interventions; treatment by the traditional African healer; counselling; supernatural and spiritual influences; punishment; depression as collective vs individualistic emotional experiences; somatisation and specific emotional difficulties related to the vocation of traditional African medicine. The research drew on information from each theme, and reflected on how the social worker or other mental health care professionals may use this to sensitize cross cultural intervention. The research paid specific attention to the individual cultural interpretations made by the traditional healer. It was emphasized that the social worker and mental health care professional alike, should be cautious of stereotyping cultural practices and interpretations of mental health by the traditional African healer.

To make recommendations for social work and other mental health intervention for further research in the area of mental health, culture and traditional African Medicine.

The research used its findings to make recommendations for social workers and mental health care workers alike for future research.

6.2.2 Aim of the study

Webster's Third International Dictionary in Fouche and De Vos (2005:104), describes the goal and objectives as 'the end to which aim or ambition is directed'. De Vos in Fouche and De Vos (2005:104) elaborates that the goal is the 'dream' or desired outcome of research intention.

Therefore the overall aims of this research may include the following:

- To explore how traditional healers understand the concept of depression or distress.
The researcher used the interview process to address how the traditional healer understands the concept of depression or distress.
- To allow for the social worker and other mental health professionals to gain a better appreciation of other paradigms beyond the medical model.
The research findings present some insights into a traditional African understanding of depression. This allows for social workers and mental health care workers alike to stretch themselves beyond biomedical understandings of depression and to appreciate alternate cultural discourse on depression.
- To examine how traditional African healers locate meaning with regard to the concept of depression
Once again this was obviously achieved through the interview process which gave the traditional African healers an opportunity to present their conceptualizations of depression.
- To highlight disparities and similarities between traditional African views and westernized allopathic concepts of depression or mood disorders. The very experience of distress or depression may be a feeling or a mood with its own unique cultural nuances.

The researcher used the analysis to code the data into relevant themes. These categorizations allowed the researcher to reflect on and present unique cultural theoretical underpinnings.

4.2.3 Research Question

The research question was: How do African traditional healers understand or interpret depression?

The data collected from the interviews relayed themes and sub-themes relating to how the participants in the sample understood depression. The research was qualitative in nature and therefore the data obtained was descriptive in nature.

The themes were related to under the following headings:

Table II- Summary of Themes

Theme 1	-Relevance of the concept of depression for the traditional healer - Sub –theme- Depression as a concept ripe in relevance - Sub-theme : Depression as a redundant term
Theme 2	-Conceptualization of the term depression -Sub-theme- Depression constructed as an experience of sadness
Theme 3	-Depression defined by traditional healers- an intuitive assessment
Theme 4	-Depression as an experience of ‘thinking too much’
Theme 5	-Depression as a result of external Circumstances
Theme 6	-Conceptualization of depression as Illness Sub-Theme- Depression as an illness in its own right Sub-Theme- Biomedical assumptions of what constitute illness and traditional African medicine
Theme 7	-Allopathic medicine, depression and curing the mind -Sub-Theme -Rejection or ambivalence regarding allopathic treatment of depression -Sub-Theme- An embrace of allopathic medicine
Theme 8	-The traditional healer and treatment of depression
Theme 9	-The traditional healer as counselor
Theme 10	-Treating body, mind and soul- depression as an experience of the supernatural, psycho social or bio chemical?
Theme 11	-The spiritual significance of depression
Theme 12	-Depersonalization of depression and punishment
Theme 13	-Emphasis on individualistic versus collective
Theme 14	-The depressing job of being a traditional healer

The themes were discussed in detail in the previous Chapter.

4.3 CONCLUSIONS

The research presented the findings of in depth interviews with a sample of traditional healers in the Johannesburg area. The research is qualitative in nature. Therefore the results cannot necessarily be transferred beyond this sample. Further research would need to be replicated to see if similar conclusions would be drawn. It should also be noted that the research is also reliant on the subjective interpretations of the researcher. However, the research still maintains that the thematic relevance of the conclusions may be indeed very useful for social workers and health practitioners to bare in mind when working in the field. The collective case study enabled the research to reflect on a random sample of traditional healers which may indeed represent a ‘slice of life’ of many traditional healers living in urbanised areas with some or little exposure to allopathic medicine. Therefore the findings although not conclusive remain relevant.

The semi structured interview was used. This enabled the researcher to inquire into her subject of interest. However, it still allowed the participants to expand where they wanted. It also allowed for the traditional healers to omit questions that were not viewed being essential.

The research offers that the traditional healers understanding of depression was fluid and indeed in a state of flux. In other words there was not a common definition or consensus of what constituted a depressive experience. The interpretation of this was dependent on a number of factors. The research findings reflected on these various interpretations made by the traditional healers.

4.3.1 Theme 1- Depression as a redundant term or ripe in relevance

The thematic relevance of the term depression of being ripe in relevance or a redundant presents the research with contradictions in terms of being redundant or relevant.

In many ways the term depression was ripe in relevance. All of the traditional healers highlighted key aspects of the condition. All of the traditional healers interviewed reflected on well known characteristics of depression as documented by many westernized bio medical and psychological paradigms. All of the traditional healers offered very rich and tangible illustrations of the condition in some form or another. Illustrations of this will be given throughout the discussion. Descriptions were made of wanting to lie down and cover oneself with a blanket. Reference was also made to an internal sickness where an individual feels sick. The isolating tendencies of the individual were also highlighted. Insomnia and the inability to sleep were also made reference to. However, despite these striking understandings of depression, the research concludes that depression was not necessarily prioritized or recognized at the forefront of traditional practice.

The researcher is of the opinion that the subject of depression is indeed not always necessarily relevant to the traditional healer. The researcher draws this conclusion by observing a common trend in the interviews. The traditional healer often hesitated when answering questions pertaining to depression. Perhaps this exemplified that indeed depression is often a redundant term for the traditional healer.

The analysis also highlighted the fact that the word was at times not understood. None of the traditional healers in the sample made reference to a similar condition. The participants did not make use of other African words or terms to describe similar experiences of distress. It was also not reflected on as an everyday experience.

The researcher concludes that depression is not a redundant term for the traditional healer. However, the nature of its relevancy is still questioned. Its relevancy relates to the fact that there are rich conceptual understandings of the condition.

Conceptualization of the term ‘depression’

4.3.2 Theme 2- Depression constructed as an experience of sadness

Sadness and depression could not always be differentiated definitively. Therefore depression was at times a transient variable. Interpretations varied. However as examined in the previous chapter, the participants agreed that depression is a more severe and at times more dangerous experience of sadness. Many of the traditional healers also recognised that depression requires more intensive treatment, while sadness is a more innocuous condition. It has also been discussed in the literature that allopathic traditions would draw specifically on diagnostic criteria to differentiate between a sad experience and a depressive experience. The traditional healer does not generally use these methods of assessment. She/he relies more heavily on personal assessments and interpretations of sadness. However, it must be said that the interpretations do still mirror some westernized understandings of depression. This included well recognized symptoms of a depressive episode: an overwhelming experience which is difficult to control; a condition which requires therapy and a condition which may precipitate taking one's life.

In conclusion, the traditional healers did for the most part recognize that there is a difference between sadness and depression. Most of their understandings reflected a distinction between depression and sadness.

4.3.3 Theme 3-Depression defined by traditional healers- an intuitive assessment

The analysis conveyed that interpretations of illnesses were subjective and intuitive. The research therefore concludes that the traditional healers interviewed could not offer a distinctive and universal explanation of depression. There was no unified perception of depression. This is in direct contrast to the medical model which leans towards more conclusive assessments and diagnoses.

4.3.4 Theme 4-Depression as an experience of ‘thinking too much’

The theme of ‘thinking too much’ was highlighted by the sample of traditional healers as a key trait in a depressive experience. The research concluded that a unified perception of a depressive experience could not be reached. However, there was still a shared understanding of what a depressive experience may look like. The research concluded that the theme of ‘thinking too much’ is a specific cognitive distortion highlighted by the traditional healer in the sample.

4.3.5 Theme 5-Depression as a result of external circumstances

External factors were highlighted by some of the traditional healers interviewed. This was accepted by the most of the traditional healers as a very legitimate cause for a depressive episode.

However, on the whole many of the traditional healers were also in agreement that a depressive experience is very much the result of an individual ‘thinking too much.’ The research is not undertaking to explore the internal versus external factors of depression. It explores how the traditional healer recognized both the external and internal aspects of depression. In conclusion some of the traditional healers made space for depression as being consequential of harsh external circumstances.

4.3.6 Theme 6- Conceptualization of depression as illness

In summation, it appears that depression was at times loosely acknowledged as an illness. However, on the whole the traditional healers did not mostly credit it as such. Therefore the research cannot draw specific conclusions as to whether traditional African medicine recognizes depression as an illness. Once again, the traditional healers’ acceptance or rejection of depression as an illness will be specific to each of the traditional healers concerned. Exposure to the medical paradigm did at times influence this perception. For example, one of the traditional healers who worked as a nurse endorsed the positioning of depression as an illness. It must also be emphasized that the recognition of depression as an illness does not necessary mean that the traditional healer will agree with an allopathic intervention for it.

4.3.6.1 Sub-Theme-Depression as an illness in its own right

Depression is at times indirectly recognized as an illness. However, it is mostly viewed as a predisposition to other illnesses or conditions. One of the traditional healers recognised the possibility that depression could be an illness due to the secondary physiological implications of being in a highly stressed state.

4.3.7 Theme 7 - Allopathic medicine, depression and curing the mind

4.3.7.1 Sub-theme-Rejection or ambivalence regarding allopathic treatment of depression

The traditional healer did appear at times to discredit the professional expertise symbolized by the ‘white coat’ of the medical doctor. There were indeed some respondents who outright rejected allopathic medicine. Other traditional healers did not metaphorically speaking ‘haul western medicine over the coals.’ However, they only recommended it as a last measure in the treatment of depression. It was offered as an alternative, when traditional medicine was not effective. Others would not commit to an opinion about allopathic medicine, due to a lack of exposure. Therefore once again we see a diverse and varied response from traditional healers. The researcher finds it most interesting that these varied opinions exist even amongst the traditional healers who prioritize their treatment over the medical field’s intervention. Therefore the research concludes that the rejection of allopathic treatment of depression by the traditional healer exists on a continuum.

4.3.7.2 Sub-theme-An embrace of allopathic medicine

There was indeed a pool of traditional healers who voiced faith in medical practices with respect to allopathic medicine. Some of the traditional healers even argued that Traditional African medicine was not equipped to treat depression. Allopathic medicine was at times endorsed as a superior alternative. Other traditional healers related that both paradigms are effective and inherently the same.

In summation, the research has explored that there were some traditional healers who esteemed both paradigms as being effective in treating depression. However, this was not a general trend. There seemed to be generally two camps of traditional healers. The first camp rejected allopathic medicine's treatment of depression as redundant, as it could not treat the mind, while the other camp argued that allopathic medicine should be endorsed with the sole task of treating depression. There were also varied responses from traditional healers who positioned themselves between the two camps.

4.3.8 Theme 8-The traditional healer and treatment of depression

The traditional healers appeared to use a variety of means to 'treat depression.' Some of the traditional healers advocated that they could not treat depression. Others reflected that prayer, and communication with ancestry could be used as a primary means for intervention. Others utilised the dispensing of herbs to treat depression. There was also debate as to whether muti could be dispensed to treat a depressive experience. Some of the traditional healers were of the opinion that neither traditional African medicine nor allopathic medicine could be used to treat depression effectively. The individual is cited as being responsible for their depression. Finally, other traditional healers recommended that the expressing of emotions should shift a depressive experience. The participants above all, prioritized guidance from ancestry to administer appropriate treatment for a depressive episode.

However, the treatment of depression was handled differently amongst the traditional healers. Once again, the research concludes that while certain aspects of treatment by the traditional African medicine remain constant, there is no single standardized treatment of depression.

4.3.9 Theme 9- Traditional healer as counsellor

It can be safely asserted that the world of traditional African medicine and the 'westernized' traditions of counselling or psychotherapy are knitted together. Traditional medicine is not just reduced to the 'hocus pocus' of throwing bones and offering muti. There is clearly a strong sense here that the traditional healer prioritizes the importance of counselling or psychotherapy 'to grow within the person (Respondent 8).' This shared interest may indeed help soften fundamental discrepancies between traditional African medicine and westernized traditions. There may be a common goal to help the patient through counselling. Therefore the traditional healer and social worker or mental health worker may share common ground. There is undeniably an overlap as to how depression may be treated. The researcher does however also acknowledge that there may be a significant different approach to the counseling process by traditional African medicine. The relaying of prophecies may also add complexity to counselling. The traditional healer may have to 'counsel' their clients with regard to the bad news which they foresee in their future.

In summation, it is not in the scope of this research to explore the efficacy of counselling by traditional African medicine versus other mental health care professions. However, the researcher still maintains that there may still be common ground by the traditional healer and the social worker in their shared duty of counselling the patient. It appears that both disciplines share a reverence for the importance of counselling.

The research found that many of the traditional healers were comfortable to take on the role of counsellor. They saw it as an integral part of their practice. Others felt that they would need to refer on to professional people like social workers and psychologists.

4.3.10 Theme 10 -Treating body, mind and soul: depression as an experience of the supernatural, psycho social or bio chemical?

The research noted that the psycho social context was often quoted as a catalyst for a depressive experience. Therefore it could tentatively be concluded that depression was viewed by the traditional healers as being an illness located in the psycho social context. However, this should not be generalized beyond this sample. Many of the traditional healers in the sample have in some way been working in urbanized context. They may have been influenced by heightened exposure to westernized influences. Some of the traditional healers in the sample had been trained as nurses. Therefore different observations may be reached if the researcher had interviewed more rural- based traditional healers. Furthermore, the research also acknowledges that the traditional healers may have chosen not to give full disclosure about their supernatural beliefs. They may have been hesitant to share their beliefs with a white researcher. They may have been doubtful as to whether the research would understand or even accept their supernatural beliefs.

The emphasis on the psychosocial context as opposed to the supernatural may partially explain why depression was not necessarily a recognizable term for many of the traditional healers. It has already been emphasized that the role of the traditional healer is mostly in the realm of the supernatural. However, the research is still of the opinion though that there cannot be a strict dichotomy between the supernatural and the psycho social context in the world of the traditional healer. The traditional healers in practice are still going to follow instruction from ancestry in their assessment of any illness or condition. Therefore all practice and understandings are inherently supernatural. The research proposes that this should be taken into consideration in making sense of the traditional healers' understanding of depression. The research still therefore maintains that the traditional healers' approach is still heavily embedded in the supernatural.

4.3.11 Theme 11-The spiritual significance of depression

The research explored the notion that the spiritual significance of depression varied amongst the traditional healer in the interviews. Some proclaimed a fervent belief in the spiritual meaning of depression for an individual. Others did not concur, and referred rather to personality variables and other life circumstances. Therefore the research offers that the possibility that depression will be spiritually significant is not set in stone. Spiritual interpretations will be specific to the traditional healer.

In the literature review, the research speculated that the spiritual or supernatural significance of a depressive episode is what would differentiate traditional healing from other paradigms of healing. However, as recognized by most of the findings thus far, there appears to be a divide with regard to the opinions of the traditional healers in their view of depression. Some traditional healers insisted on the spiritual significance of a depressive experience, while others explored other variables. The research argues that this may be because of a lack of a definitive explanation of depression by traditional African medicine. For the most part depression really does remain an allopathic construction.

The research recognizes that the ancestors may offer individual assessment and instruction regarding a depressed person. However, it seems that in the terrain of depression, many of the traditional healers are left to draw understandings from their own frames of reference and understanding.

4.3.12 Theme 12-Depersonalization of depression and punishment

Depression was for the most part, not viewed as a punishment, but as a normative response to difficult life circumstances which can affect anyone. Interestingly enough many of the traditional healers normalised a depressive experience. In this way, it is seen as being non discriminatory which can affect anyone from any walk of life. However, there was also some belief that depression may be a rebuke from ancestry. Therefore depression was not seen unanimously as a punishment. Once again, interpretations of depression as a punishment or as random will be specific to the individual traditional healer.

4.3.13 Theme 13-Individualistic versus collective cultures

It was difficult to assess whether the traditional healers in the sample's interpretation of a depressive experience are more indicative of an individualistic or a collective culture. As explored in the analysis many of the traditional healers related to more of the individualistic representations of a depressive experience, while others also reflected on the relevance of a collective culture.

The research questions whether such a clear cut distinction between individualistic and collective cultures is useful in understanding the positions of the traditional healers interviewed.

It has been mentioned in previous chapters that the traditional healers interviewed were all living in Johannesburg. None of the traditional healers interviewed were working solely as traditional healers. As noted previously some were cleaners, domestic workers and some were nurses working in medical setting.

Therefore the research argues that there is some level of individuation, and some westernized influence. The research speculates that these traditional healers living out of the grip of a deeply rural setting are more likely to adopt some level of individualization.

Therefore there may be greater flexibility from this sample in terms of negotiating the collective consciousness of a traditional African sample. This may impact on their understanding of the emotive experience of depression. This may be the result of the traditional healers having higher levels of individuation and greater acculturation into westernized cultures. Therefore this research cannot be generalized beyond the sample.

The research will argue that the traditional healers' construction of depression exists on a continuum between a collective versus an individualistic experience. The traditional healers made large reference to how harsh psychosocial circumstances may impact the individual. They also made reference to how the patient may suffer from individual maladaptive cognitive dysfunctions. Individual personality variables were also alluded to. In this way a strong argument may be made for an individualistic depressive experience.

However, the research also uses the process of the interviews as offering interesting and contradictory insights. It is fascinating to note that an experience of depression may not always be acknowledged and given a space by African culture. The traditional healers answered questions on depression and offered poignant illustrations of the subject. However, as previously repeated, the researcher sometimes felt the topic of depression was not an everyday one. It did not always seem an easily accessible topic for the traditional healer. As mentioned earlier, the traditional

healers at times needed time to think about answering some of the questions posed on depression. It did not appear that it was a subject that was very familiar and relevant to them in practice. There was rather more of an indirect acknowledgement of depression. They answered questions specifically on depression because it was posed by the researcher. The research speculates that had they been given free reign to discuss anything relevant from their everyday practice, depression would probably not be high on their list of priorities. This presents an interesting contradiction. The relevance of depression for the traditional healer is secondary. This is despite the fact that the traditional healers offered poignant illustrations of the psycho social component and intra psychic aspects of depression.

The research offers that the traditional healers' lack of experience in treating or prioritizing it, may in fact be due to the fact that traditional healers' viewpoints are still primarily based in a collective cultural framework. The research speculates that indeed these contradictions reflect some of the cultural times. The traditional healer and black South African may indeed be exposed to both westernized influence and traditional ones. Consequently, the traditional healer may be left with a foot in each world of medical practice. This means s/he forms and perhaps practices his/ her own brand of traditional African medicine.

4.3.14 Theme 14 -The depressing job of being a traditional healer

At times traditional healing was constructed as being a very stressful job. This was related to getting the call to be a traditional healer. It was also due to relaying ominous prophecies to patients.

4.3.15 Theme 15-Somatisation

Most of the traditional healers did not reflect on somatic complaints. Only one of the traditional healers made reference to somatisation. However, the research is reminded of the fact that traditional African medicine combines the physical and emotional in a holistic assessment process. Therefore the possible relevance of a dynamic of somatisation should not be disregarded, even though it did not come out as a predominant theme in this research.

Table III- Synopsis of conclusions from study

Themes	Key Findings
Theme 1- Depression as a redundant term or Ripe in Relevance	The traditional healer seemed to portray rich understandings of a depressive experience. However, it was not recognized as a condition on the forefront of practice.
Conceptualization of the term 'depression' Theme 2- Depression constructed as an experience of sadness	Depression and sadness were viewed for the most part as being different. Depression was viewed as a more intense experience of sadness with more serious implications.
Theme 3- Depression defined by traditional healers-an intuitive assessment	Assessments of a depressive experience remain intuitive and subjective. Therefore no singular interpretation of a depressive experience can be achieved.

Theme 4- Depression as an experience of ‘thinking too much’	The traditional healers recognized the cognitive distortion of ‘thinking too much’ as a common variable in a depressive experience.
Theme 5- Depression as a result of external Circumstances	Difficult external circumstances were viewed as being significant contributing factors to a depressive episode.
Theme 6- Conceptualization of depression as illness	Depression was not viewed conclusively as an illness. Traditional healers who worked in the medical field allowed for more concessions for it to be viewed as such. Recognition of depression as an illness did not necessarily condone medical intervention.
Sub-Theme-Depression as an illness in its own right	There was a definite shared perspective that depression could precipitate other illnesses or conditions. This view was favoured in contrast to depression being seen as an independent illness.
Theme 7- Allopathic medicine, depression and curing the mind Sub-theme-Rejection or ambivalence of allopathic treatment of depression Sub-theme- An embrace of allopathic medicine	There was a definite argument from some the traditional healers for the rejection of allopathic medicine. It was also recorded that there was great ambivalence from the sample on allopathic medicine. Alternatively, a pool of the sample endorsed allopathic medicine. Therefore the rejection or embrace of traditional African medicine was very much dependent on the individual traditional healer.
Theme 9- Traditional healer as counsellor	Counselling is prioritized in practice. Some of the traditional healers took on counselling as part of their consultation. Others referred on to other mental health care professionals.
Theme 10- Treating body, mind and soul: Depression as an experience of the supernatural, psycho social or bio chemical?	The traditional healers recognized the importance of the psychosocial context with regard to depression. However, the research still concludes that the relevance of the supernatural in a depressive experience is paramount.
Theme 11-The spiritual significance of	Spiritual interpretations differed

depression	amongst respondents. The spiritual significance appears to be reliant on each traditional healer's frame of reference. The value of ancestral interpretation cannot be neglected in the spiritual meaning making process.
Theme 12- Depersonalization of depression and Punishment	There was a split amongst the sample. Depression was normalized amongst some of the respondents. Others saw it as punishment from the ancestry.
Theme 13- Individualistic versus collective Cultures	Depression may be seen as being on a continuum in terms of it being located in more of an individualistic versus collective culture. The traditional healers appeared to have one foot in each of these cultural practices.
Theme 14- The depressing job of being a traditional healer	The traditional healers experienced a significant amount of distress in their vocation as traditional healers. This appeared to be mostly related to relaying bad news to patients. The experience of 'getting the call' to become a traditional healer was also quoted as being a distressing experience.
Theme 15-Somatization	Somatisation was not viewed as having significant thematic relevance. However, the research still does not deny its possible worth.

4.4 Recommendations

The recommendations will now be made in accordance with the themes.

4.4.1 Recommendations per research themes

Theme 1-Depression-ripe or redundant

Social workers and health care professionals should not make assumptions that the concept of depression is necessarily recognized and prioritized by traditional healers. However, it should not be presumed that depression is an area in which the traditional healer is not acquainted with.

The social worker and health care professional alike, should ensure that they respect and work within the traditional healer's frame of reference regarding depression.

Theme 2-Depression constructed as an experience of sadness

The social worker should be receptive to work with the traditional healer's possible rich understandings of sadness versus depression. A great deal can be lost if in collaboration social workers do not heed attention to this.

The research proposes that medical diagnostic criteria may be used tentatively as a road map in assessing sadness as an experience of depression. The research therefore calls on the social worker not to rely heavily on medical paradigm's diagnostic criteria on depression. It may be useful for the social worker and the traditional healer to draw on parallels and build on similar ways of working in understanding depression and sadness. The social worker may however, be able to offer other information on depression versus sadness from other paradigms. For example, the social worker may play an educative role in offering information on DSM-IV criteria, and/or The Person in Environment assessment tools on depression versus sadness.

Theme 3-Depression defined by traditional healers-An intuitive assessment

The social worker also needs to be cognisant of the traditional healer's intuitive assessment of clients. Therefore no presumptions should be made as to how the traditional healer understands or assesses the depressed client. This will rather be dependent on the individual traditional healer's intuitive assessment processes.

It may be useful for the social worker to further educate him/herself on the intuitive assessment process that the traditional healer adopts. This should ensure a progression in the social worker's potential to master cultural competence in this field.

The social worker should also take the opportunity to reflect on his/her use of intuition in practice, and highlight where this could be useful. The traditional healer and social worker may be able to use their combined intuition in assessing and assisting the patient.

Theme 4- Depression as an experience of 'thinking too much'

The research recognized that the sample concluded that 'thinking too much' is a specific trait in a depressive experience as recognized by traditional healers. It may be useful for further research to be conducted in this area in order to verify this. The social worker and other mental health workers should bear in mind the variable of 'thinking too much' when working with traditional African healers and/ or the 'depressed' traditional African client. The traditional African healer and social worker may be able to work together and use their joint skills in challenging the patient's cognitive distortions.

Theme 5- Depression as a result of external circumstances

There may be scope in practice for the social worker and traditional healer to join forces and work together in treating and assessing the depressed client with regard to external circumstances. The social worker and traditional healer should put 'their heads together' in assisting patient's with a 'reactive' depression.

However, attention should be drawn to the fact that traditional healers may differ in their opinion of depression as being the result of an internal processes or external circumstances. Once again in working with the traditional healer, it may be useful to decipher whether the traditional healer

locates the experience as more of a reactive experience due to external circumstances or to internal processes. This may aid the social worker in gaining even more insight as how the traditional healer understands the particular depressed client. It also enables the social worker to appreciate the traditional healer's intervention with the depressed client in relation to this.

Theme 6- Conceptualization of depression as illness

The social worker and medical professional alike should be aware that the traditional healer may not recognize depression as an illness. The health care professional should also make room for the fact, there may be ambivalence and uncertainty amongst the traditional healers in conceptualizing depression as an illness. Therefore the social worker should once again be open to all possibilities in conceptualizing depression.

The social worker can here play a role in educating the traditional healer about the possibilities of seeing depression as an illness.

Sub-Theme-Depression as an illness in its own right

The social worker should also be aware that the traditional healer's acknowledgement of depression as an illness, does not necessarily translate with an agreement of a biomedical intervention.

The traditional healer may only recognise depression in terms of the harmful impact of stress on the body. If this is the case, the social worker and traditional healer may work together in helping individuals improve their stress management. The social worker may also assist the patient in developing better life skills to cope with depression or mental illness. This may be prioritized as a preventative measure to avoid other physical or health related issues.

Theme 7 - Allopathic medicine, depression and curing the mind

Sub-theme-Rejection or ambivalence about allopathic treatment of depression

The social worker may need to be sensitive to the specific traditional healer's opinion of allopathic medicine in treating a depressed patient. The social worker should respect what the traditional healer believes would be appropriate treatment.

There should be an understanding that the traditional healer may reject the use of allopathic medicine in treating depression. The social worker may also need to be prepared that the traditional healer may believe that the depression may be caused by muti poisoning or a punishment from ancestry.

Sub-theme-An embrace of allopathic medicine

The social worker should be careful not to stereotype the traditional healer. There should be an openness to the possibility that the traditional healer may embrace allopathic medicine. As previously repeated, the social worker may be able to inform the traditional healer concerned about the potential benefits of allopathic medicine in the treatment of depression.

There may also be an opportunity for social workers to network between traditional healers and medical specialists in the field of depression. There may indeed be great possibilities for the

traditional African healer and allopathic practitioner to collaborate and draw on each other's skills and resources in the interest of the patient. This should greatly assist all South Africans to reap the benefits and teachings of both paradigms.

Theme 8-The traditional healer and treatment of depression

The social worker should acquaint him/herself with the traditional healer's treatment. The social worker should consider that there may be no singular treatment plan by the traditional healer. However, the social worker should also be astute to the fact that reverence for ancestry may be paramount in all forms of treatment.

Theme 9-The traditional healer as counsellor

The social worker should take gain more information as to whether the traditional healer concerned offers counselling to patients. Care should be taken to assess what this process entails. The social worker may also be able to offer his/her counselling skills if need be.

Theme 10-Treating body, mind and soul: Depression as an experience of the supernatural, psycho social or bio chemical?

The social worker needs to remain attuned to the subtle overtones in achieving cultural competence in working in collaboration with the traditional healer. The research conjectures that this may be partially achieved in respecting the traditional healer's devotion to the ancestors. The social worker should bear this in mind as a possibility when assessing a traditional African patient. The social worker may need to query where the traditional healer locates depression in relation to the supernatural , psycho social or bio medical. It has already been explored that the social worker prioritizes influences from the psycho social context. Therefore the social worker and traditional healer may use this commonality in their intervention with the depressed client.

Theme 11-The spiritual significance of depression

The social worker and other mental health care professionals should allow for individual interpretations of the spiritual significance of an episode. Care should be taken to respect possible interpretations given.

Theme 12-Depersonalization of depression and punishment

The social worker may need to explore whether the traditional healer views depression as a punishment or a more impersonal experience.

It has been established that there is scope for depression to be viewed as a punishment from the traditional African healing world. It may be important to differentiate where the experience of being 'punished' resides. It may be primarily an emotional experience of being 'punished' or a cultural belief that s/he is being punished.

In conclusion, the social worker also needs to sensitize her/his self to the possibility that depression may in fact be believed to be a punishment from ancestry. Therefore the social worker may need to assess whether accounts of depression are reflective of an internal persecutory world or a belief that s/he is literally being punished by ancestry.

Theme 13-Individualistic versus collective cultures

The social worker should therefore make sure s/he is in touch with whether depression is located by the traditional healer within an individualistic cultural framework or a collective one. For example the social worker may need to explore whether the client is depressed because of a personal and individual experience, or whether the individual is depressed because s/he has displeased the community/ancestors, or has not complied with certain cultural practices?

Theme 14- The depressing job of being a traditional healer

Social workers may be able to play a supportive role for traditional healers through the emotional difficulties related to being a traditional healer.

Theme 15-Somatization

It is recommended that the social worker remain aware of possible issues of somatisation in the work of mental illness and depression.

4.4.2 Recommendations for social workers

Subsequently the recommendations for social workers in practice will be provided in a table.

Table IV-Recommendations for social workers

Theme 1- Depression-ripe or redundant	The social worker should not make assumptions of whether the traditional healer would recognize a depressive experience. Care should be taken to work from the traditional healer's frame of reference.
Theme 2- Depression constructed as an experience of sadness	The social worker should remain attuned to the traditional healer's construction of depression versus sadness. This will have implications for treatment. The social worker should be aware of this and draw on parallel ways of working. The possibility may also exist for the social worker to inform the traditional healer of alternate medical paradigms, and how they differentiate between sadness and depression.
Theme 3- Depression defined by traditional healers-an intuitive assessment	The social worker should be mindful of the traditional healer's intuitive assessment process. This may include gaining cultural competence as to how the ancestors may mould the assessment process. Respect should be given to the fact that there may be no singular interpretation of a depressive episode. Social workers should also explore their own use of intuition in assessment. This may be adopted as a means to collaborate with the

	traditional healer.
Theme 4- Depression as an experience of 'thinking too much'	The social worker should be cognizant of the variable of 'thinking too much' as a common theme shared by traditional healers when working with depression. The traditional healer and social worker may be able to unite in working with the typical cognitive distortions which may be present for the depressed client.
Theme 5 - Depression as a result of external circumstances	The social worker should weigh the traditional healer's prioritization of external circumstances in a depressive episode. There may be a joining in helping the client with harsh external circumstances which may contribute to a depressive experience.
Theme 6- Conceptualization of depression as illness	Traditional healers will vary in their opinion as to whether they think depression is an illness. The social worker should be open to all possibilities. Once again, the social worker may provide information on how the biomedical model may view depression as an illness.
Theme 7- Allopathic medicine, depression and curing the mind Sub-theme-Rejection or ambivalence about allopathic treatment of depression Sub-Theme-Depression as an illness in its own right	The social worker should be aware that the traditional healer may reject the use of allopathic medicine. This may be due to the fact that the traditional healer may believe that muti or the ancestors are involved in the depressive experience. The traditional healer may also reject allopathic medicine as they may believe that this medicine is not holistic in nature. The social worker may his/herself here offer a bridge between allopathic medicine and traditional healing, in the prioritization of the holistic contexts.
Theme 8- The traditional healer and treatment of depression	The social worker should familiarize him/herself with various modes of treatment and bare in mind the traditional healer's reverence for ancestry.
Theme 9- The traditional healer as counsellor	The social worker should use the traditional healer's prioritization of the counselling process to build bridges. The social worker should be open to the fact that the traditional healer may assume the role of counsellor or refer out.
Theme 10- Treating body, mind and soul: depression as an experience of the supernatural, psycho social or bio chemical?	The social worker should pay attention to the fact that the traditional healer's approach is inherently supernatural. However the traditional healer may be open to recognising in particular

	psycho social influences and even bio chemical influences.
Theme 11- The spiritual significance of depression	It should be reflected that the traditional healer may or may not concede to the spiritual significance of a depressive episode.
Theme 12- Depersonalization of depression and punishment	The traditional healer's view of depression as a punishment will be dependent on the traditional healer. The social worker may need to do individual assessments of both the traditional healer and the client's viewpoint of depression as a punishment.
Theme 13- Individualistic versus collective cultures	The social worker will need to explore whether the traditional healer's locates a patient's depression in the realm of an individualistic based culture or a collective based culture.
Theme 14- The depressing job of being a traditional healer	There is potential for the social worker to pay a supportive role for the traditional African healer. This may be in relation to the stressors the traditional African healer may face in relation to their job.
Theme 15- Somatisation	The social worker should be sensitive to the process of somatisation.

4.4.3 Recommendations in the broader context

The researcher summarizes the recommendations into four main areas. These include: cultural competence, drawing on similarities in practice and collaboration, and education and recommendations for future research.

Cultural Competence

In summation the social worker needs to gain cultural competence in the following areas:

- The social worker should do individual assessments of the traditional healer's view of depression versus sadness and implications for assessment and intervention.
- Care should be taken to stretch beyond allopathic or medical assessments when working with the African traditional healer or the 'traditional' African patient.
- The social worker should be mindful of the intuitive assessments made by the traditional healer, and reverence for ancestry. The social worker should educate him/herself with regard to this.
- Similarly, the traditional healer's reverence for ancestry should be respected.
- The concept of 'thinking too much' may be possibly recognised by the traditional healer in understanding depressive episodes. The social worker may need to look out for this observed trend.

- The concept of depression as an illness will be dependent on the individual traditional healer's interpretation. The social worker should be aware of this, and possible implications. Similarly, depression may or may not be viewed as an independent illness.
- The social worker should be mindful of the fact that the traditional healer may embrace/ reject allopathic medicine and explore implications.
- There should be a cultural awareness that muti and ancestry may be believed to be the catalyst and cause of depressive episodes.
- The social worker should understand that the traditional healer's approach will be inherently supernatural.
- The social worker should be open to the possibility that the traditional healer may interpret the spiritual significance of a patient's depressive experience. This is not, however, universal.
- The traditional healer may or may not assume the role of a counsellor for a depressed patient.
- Depression may or may not be viewed as a punishment. The social worker will need to assess the thematic relevance of feelings of persecution. It will need to be deciphered as to whether this is related to depression being inflicted as a real external curse, or whether it is harboured by the patient as an internal experience of being persecuted.
- Depression may be located within an individualistic/collective cultural framework. The social worker should be aware of this, and possible implications.

Collaboration

The research reflected that there is indeed shared common ground between the traditional healer and the social worker. It is recommended that the social worker pay attention to these as a means to join ties in practice.

- The social worker should be aware that the practice of traditional African healing emphasizes the importance of working with the patient/client in a holistic manner. Both modalities should learn about each other's way or working holistically to enhance joined intervention. For example the social worker may be able to introduce the traditional healer to the P.I E practice of assessment and diagnosis.
- The traditional healers affirmed the harmful impact of stress/depression on the body. The social worker and traditional healer may be able to join forces in the community. Focus may be on stress reduction and healthy living.
- It appears that on the whole both the social worker and traditional healer prioritize counselling and psychosocial interventions.

Education and mediation

- The social worker may serve as mediator between the allopathic paradigm and the traditional African paradigm. This may become an ever increasing prioritized focal point. The South African patient may be exposed to both paradigms, and may need to find a niche in the middle.
- The social worker may play an educative role for both allopathic medicine and traditional African medicine to learn about each other's ways of working. The social worker would hopefully be able to achieve this in a respectful manner which encourages mutual understanding. This should hopefully combat stigma and myth.
- It has been previously mentioned that the social worker may be able to introduce the P.I.E tool as an alternative assessment tool to both paradigms in the field of mental health.
- The social worker may always play a fundamental role in de-stigmatizing depression in a manner which still respects cultural practices.

Future Research

- The research should be replicated to establish greater validity, reliability and transferability.
- The research should be streamlined to explore understandings of traditional African healers in other contexts. For example it would be interesting to compare data from a sample of traditional healers in the rural areas.
- Research could also be done to explore how the depressed patient experiences the traditional African healer's assessment and treatment of their condition versus allopathic paradigms.
- It would be interesting to explore what constitutes the training in counselling for the traditional healer.

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APPENDICES
APPENDIX 1:ETHICAL APPROVAL LETTER



UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

Faculty of Humanities
Research Ethics Committee

14 October 2009

Dear Prof Lombard,

Project: African traditional healers' understanding of depression as a mental illness: implications for social work practice
Researcher: Starkowitz M
Supervisor: Dr C Carbonatto
Department: Social Work and Criminology
Reference number: 27417736

Thank you for your response to the Committee's letter of 7 May 2009.

I have pleasure in informing you that the Research Ethics Committee formally **approved** the above study at a meeting held on 8 October 2009. The approval is subject to the candidate abiding by the principles and parameters set out in her application and research proposal in the actual execution of the research.

The Committee requests you to convey this approval to Ms Starkowitz.

We wish you success with the project.

Sincerely



Prof. Elsabé Taljard
Acting Chair: Research Ethics Committee
Faculty of Humanities
UNIVERSITY OF PRETORIA
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Research Ethics Committee Members: Prof T Bakker; Prof M-H Coetzee; Dr A du Preez; Dr JEH Grobler; Prof KL Harris; Ms H Klopper; Prof E Krüger; Prof A Mlambo; Dr C Panebianco-Warrens; Prof G Prinsloo; Dr C Puttergill; Prof H Stander; Prof E Taljard (Acting Chair); Dr J van Dyk; Mr FG Wolmarans

Faculty of Humanities
Department of Social
work & Criminology

LETTER OF INFORMED CONSENT

Principal Investigator: Monique Starkowitz
Institution: University of Pretoria
Address: 45 Melrose Gate
Noordhoek Close
2106

Participant's Name:

Date:

My name is Monique Starkowitz and I am doing my Masters degree in Social Work in Health Care, at the Department of Social Work and Criminology, University of Pretoria. I am inviting you to participate in my research project, as part of the requirements for my degree. The aim of this study is to explore how Traditional African healers understand depression as a mental illness.

This letter will enable you to decide whether you would like to participate in this study or not. It is important that you understand what the study involves, before you agree to participate. If there is anything in this letter which you do not understand, please do not hesitate to ask. You should not agree to take part unless you are completely satisfied about what is expected of you. If you sign this letter, it means that you are giving your informed consent.

If you agree to participate, the researcher will conduct a personal interview with you. The focus of the interview will be to explore your ideas or understanding of depression as a traditional healer. It will also explore how you treat someone who complains that they feel depressed or sad. The interview will take approximately an hour, to an hour and half. There are no right or wrong answers. The researcher purely wants to hear your opinion.

The interviews will be conducted at a venue which will suit you and the researcher. The researcher will discuss this with you closer to the time. The researcher will in no way reveal any of your personal identifying information in the research report and no personal reference will be made to you. Your name will not be used, but a number, once the data has been collected, in order to ensure that your confidentiality is protected. Data that will be reported in scientific journals will not include any information that identifies you or any participant in this study.

You are free to withdraw from the study at any time. There will be no penalties for withdrawing. Your participation is voluntary and you will receive no benefits or payment for participating.
Yours sincerely,

MONIQUE STARKOWITZ
RESEARCHER

Informed Consent

1. *Title of Study:* African Traditional Healers' understanding of depression as a mental illness: implications for Social Work
2. *Purpose of the Study:* The purpose of this study is to investigate how the Traditional African healer understands depression.
3. *Procedures:* The interviewing will take approximately 1 to 1 and half hours. All interviewing will be scheduled at my convenience.
4. *Risks and Discomforts:* There are no known medical risks or discomforts associated with this project, although I may experience fatigue and/or stress when undergoing this interview.
5. *Benefits:* I understand there are no known direct medical benefits to me for participating in this study. However, the results of the study may help researchers gain a better understanding of how we as traditional healers learn and recall information about other people.
6. *Participant's Rights:* I may withdraw from participating in the study at any time.
7. *Financial Compensation:* I will not be re-imbursed for my participation and or any travel expenses.
8. *Confidentiality:* In order to record exactly what I say in the interviews, a tape recorder will be used. The tape will be listened to only by the Principal Investigator and authorized members of the research team at the University of Pretoria, if necessary.
9. I understand that the results of interviews will be kept confidential unless I ask that they be released. The results of this study may be published in professional journals or presented at professional conferences, but my records or identity will not be revealed unless required by law.
10. If I have any questions or concerns, I can call the researcher Monique Starkowitz at (082) 572 8706 at any time during the day or night.

I understand my rights as a research participant, and I voluntarily consent to participation in this study, I understand what the study is about and how and why it is being done. I will receive a signed copy of this consent form.

Subject's Signature

DATE

Signature of Investigator

DATE

Faculty of Humanities
Department of Social
Work and Criminology

LENGWALO LA TUMELELO KA TSEBO YE E TŠETŠEGO

Monyakišiši-mogolo: Monique Starkowitz

Institšušene: Yunibesithi ya Tshwane:

Aterese: 45 Melrose Gate

Noordhoek Close

2196

Leina la Mokgathatema:

Tšatšikgwedi:

Leina la ka ke Monique Starkowitz. Ke dira tikrii ya *Masters* ya Bodirela Leago go tša Tlhokomelo ya Maphelo ka Lefapheng la tša Bodirela Leago le Thuto ya tša Bosenyi, Yunibesithi ya Tshwane. Ke le mema go kgatha tema mo protšekeng ya ka ya dinyakišišo, tše e lego karolo ya dinyakwa tša gore ke be le maswanedi a go abelwa tikrii. Maikemišetšo a dinyakišišo tše ke go utolla ka moo dingaka tša Setšo sa Seafrika di kwešišago go nyama mooko bjalo ka bolwetši bja monagano.

Lengwalo le le tla go thuša go tšea sephetho sa ge e ba o ka rata kgatha tema go dinyakišišo go ba aowa. Go bohlokwa gore o kwešiše gore dinyakišišo di bolela ka eng, pele o dumela go kgatha tema. Ge e le gore go na le se sengwe ka mo lengwalong le seo o sa se kwešišego, ka kgopelo se dikadike go mpotšiša. Ga se wa swanela go dumela go kgatha tema, go fihlela ge o šetše o kgotsofetše ka botlalo ka seo se nyakegago go wena. Ge o saena lengwalo le, go šupa gore o fana ka tumelelo ya gago ka tsebo ye e tletšego.

Ge e le gore o dumela go kgatha tema, monyakišiši o tla swara dipoledišano le wena. Nepokgolo ya dipoledišano e tla ba go hwetša dikgopolo goba kwešišo ya gago ka go nyama mooko/kgatelelo ya monagago bjalo ka ngaka ya setšo. Gape di ka utolla ka moo o alafago motho yo a llogo ka gore o ikwa a na le kgatelelo ya monagano goba a nyamile. Dipoledišano di tla tšea tekano ya iri go ya go iri le seripagare. Ga go na dikarabo tša nepagetšego goba tše di phošetšego. Se monyakišiši a se nyakago ke go kwa maikutlo a gago.

Dipoledišano di tla swarwa lefelong leo le loketšego wena le monyakišiši. Monyakišiši o tla rerišana le wena ka seo ge nako e batamela. Ga go ka moo monyakišiši a ka phatlalatšago tshedimošo ye e ka utollago gore o mang ka mo pegong ya dinyakišišo e bile ga go na seo se tla amantšhwago le wena. Maina a gago a ka se šomišwe, eupša go tla šomišwa nomoro, morago ga gore tshedimošo e kgoboketšwe, go netefatša gore tshedimošo mabapi le wena e a šireletšwa.

Tshedimošo ye e tla tšwelelago go ditšenale e ka se akaretše tshedimošo efe goba efe yeo e tšweletšago maina a gago goba mokgathatema ofe goba ofe ka dinyakišišong tše.

O dumeletšwe go ikogela morago mo dinyakišišong nako efe goba efe. Go ka se be le dikotlo tše di ka bago gona ge o ikogela morago. Go kgatha tema ga gago ga se kgapeletšo, le gona o ka se amogeke kholego goba go lefša ge o kgatha tema.

Ka boikokobetšo,

MONIQUE STARKOWITZ
MONYAKIŠIŠI

Tumelelo ka tsebo ye e tletšego

1. *Thaetlele ya Dinyakišišo:* Kwešišo ya Dingaka tša Setšo sa Seafrika ka go nyama mooko bjalo ka bolwetši bja monagano: go šupa eng go Bodirela Leago.
2. *Nepo ya Dinyakišišo:* Nepo ya dinyakišišo tše ke go nyakišiša ka moo dingaka tša Setšo sa Seafrika di kwešišago go nyama mooko/kgatelelo ya monagano.
3. *Ditshapedišo:* Dipoledišano di tla tšea tekano ya iri go iša go iri le seripagare. Dipoledišano ka moka di tla beakanywa ka nako yeo ke itokišitšego.
4. *Dikotsi le go se ipshine:* Ga go na dikotsi le go se ipshine tšeo di tsebegago tše di sepelelanago le protšeke ye, le ge e le gore go na le kgonagalo ya gore nka itemogela go lapa le/goba go kgatelelo ya monagano ge ke tsenetše dipoledišano tše.
5. *Dikholego:* Ke kwešiša gore ga go na dikholego tša kalafo tša thwii tšeo di tsebegago tše ke tla di abelwago ge ke kgatha tema mo dinyakišišong tše. Le ge go le bjalo, dipoelo tša dinyakišišo tše di ka thuša banyakišiši go ba le kwešišo ye kaone ka fao rena bjalo ka dingaka tša setšo re ithutago le go kwešiša kgatelelo ya monagano ka gona.
6. *Ditokelo tša Mokgathatema:* Nka ikogela morago ka go se sa kgatha tema go dinyakišišo nako efe goba efe.
7. *Go phumulwa meokgo ka Tšhelete:* Nka se lefelwe tšhelete ya go kgatha tema le/goba ditshenyegelo dife goba dife tša senamelwa.
8. *Khupamarama:* Gore go rekotiwe ka tshwanelo seo ke se bolelago nakong ya dipoledišano, segatiša-mantšu se tla šomišwa. Segatiša-mantšu se tla theeletšwa feela ke Monyakišiši Mogolo le maloko ao a dumeletšwego a sehlopha sa dinyakišišong mo Yunibesithing ya Tshwane, ge go nyakega.
9. Ke kwešiša gore dipoelo tša dinyakišišo di tla bolokwa bjalo ka khupamarama, ka ntle ga ge nka kgopela gore di lokollwe. Dipoelo tša dinyakišišo tše di ka gatišwa go ditšenale tša maemo a godimo goba tša alwa dikopanong tša maemo a godimo, eupša direkote goba maina a ka a ka se tsebišwe ka ntle le ge go ka fiwa taelo ke molao.
10. Ge e le gore ke na le dipotšišo goba dipelaelo, nka letšetša Monique Starkowitz mo go (082) 572 8706 nakong ye nngwe le ye nngwe mo mosegareng goba bošego.

Ke kwešiša ditokelo tša ka bjalo ka mokgathatema dinyakišišong, le gona ke fana ka tumelelo ye, ke kwešiša seo dinyakišišo di bolelago ka sona le gore di sepetšwa bjang le gona ka baka la eng. Ke tla hwetša khopi ye e saennwego ya foromo ye ya tumelelo.

Tshaeno ya Mofetodi

Tšatšikgwedi

Tshaeno ya Monyakišiši

Tšatšikgwedi



Faculty of Humanities
Department of Social work &
Criminology

NCWADI YEMVUME ECHAZIWE

Umphenyi Omkhulu: Monique Starkowitz
Isikhungo: University of Pretoria
Ikheli: 45 Melrose Gate
Noordhoek Close
2106

Igama loMhlanganyeli:

Usuku:

Igama lami ngingu-Monique Starkowitz ngenza iziqu kwezenhlalakahle emkhakheni wezempilo, i-Masters degree in Social Work in Health Care, eMnyangweni we-Social Work ne-Criminology, eNyuvesi yasePitoli. Ngiyakumema ukuthi ubambe iqhaza ocwaningweni lwami, oluyingxenye yezidingo zokufeza iziqu zami. Injongo yalolu cwaningo ukufuna ukuthi ngabe abelaphi bendabuko base-Afrika bayiqondisisa kangakanani ingcindezi njengesifo sengqondo.

Le ncwadi eyokuthi ukwazi ukuthatha isinqumo sokuthi ngabe uyathanda yini ukubamba iqhaza kulolu cwaningo noma cha. Kubalulekile ukuthi ukuqonde ukuthi lolu cwaningo luphetheni, ngaphambi kokuthi uvume ukubamba iqhaza. Uma kukhona okukule ncwadi ongakuzwa kahle, sicela ungakungabanzi ukukubuza. Akufanele uvume ukubamba iqhaza ngaphandle kokuthi uneliseke ngokuphelele mayelana nalokho okulindeleke kuwe. Uma usayina le ncwadi, kusho ukuthi unikeza imvume yakho oyichazelwe kahle.

Uma uvuma ukuhlanganyela, umcwaningi uyobe eseqhubeka axoxisane nawe ngqo. Okuyobe kuqondiwe ngale ngxoxo wukufuna imibono yakho noma ulwazi lwakho ngengcindezi njengomelaphi wendabulo. Kuyobuye kufunwe nokuthi umelapha kanjani umuntu okhala ngokuthi uzizwa enengcindezi noma enomunyu. Ingxoxo iyothatha okungenani ihora kuya ehoreni elilodwa nesigamu. Azikho izimpendulo okuyizo noma okungeyizo. Umcwaningi ufuna ukuzwa umbono wakho.

Lezi zingxoxo ziyohutshwa endaweni eyohambisana nawe kanye nomcwaningi. Umcwaningi uyokuhlela nawe lokhu uma sekusondele isikhathi. Umcwaningi ngeke alokothe aveze noma yikuphi okuyimininingwane eqondene nawe ngqo embikweni wocwaningo futhi ngeke uphathwe nokuphathwa wena. Igama lakho ngeke lisetshenziswe, koba yinombolo kuphela, uma nje seluqoqiwe ulwazi, ukuze kuqinisekise ukuthi okuyisifuba sakho kuvikelwe. Ulwazi okuyobikwa ngalo emabhukwini obuchwepheshe besayensi ngeke luphathe noma yimiphi imininingwane engakuveza wena noma yimuphi omunye wabahlanganyeli balolu cwanningo.

Ukhululekile ukuthi uhoxe kulolu cwanningo nganoma yisiphi isikhathi. Ngeke kube khona zijeziso ngenxa yokuhoxa. Ukubamba kwakho iqhaza kusothandweni lwakho futhi ngeke kube khona zinzuzo noma nkokhelo ngenxa yokuhlanganyela.

Owakho ozithobayo,

MONIQUE STARKOWITZ

UMCWANINGI

Imvume Echaziwe

11. *Isihloko soCwaningo*: Ukuqondisisa kwabaLaphi beNdabuko baseAfrika ingcindezi njengesifo sengqondo: imiphumela kwezeNhlalakahle
12. *Injongo yoCwaningo*: Injongo yalolu cwanningo ukuphenya ukuthi ngabe abaLaphi beNdabuko baseAfrika bayiqondisisa kanjani ingcindezi.
13. *Inqubo*: Ukuhlola kuyothatha okungenani ihora-1 kuya ehoreni nesigamu. Konke ukuhlolwa kuyohlelelwa isikhathi esingivumelayo.
14. *Izingozi kanye nezinkathazo*: Azikho izingozi kanye nezinkathazo ngokwempilo ezaziwayo ezihlanganiswa nalo mklamo, kodwake kungenzeka ngifikelwe yimizwa yokukhathala kanye /noma ukugqilazeka ngesikhathi ngisaqhubeka nale ngxoxo.
15. *Izinzuzo*: Ngiyakuqondisisa ukuthi azikho izinzuzo kwezempilo ezaziwayo eziqondene nami ngqo ezihambisana nokuhlanganyela kulolu cwanningo. Kodwake, imiphumela yocwaningo ingase isize abacwaningi ukuthi bathole ukuqonda kangcono ukuthi thina balaphi bendabuko sifunda futhi sikhumbule kanjani ulwazi olumayelana nabanye abantu
16. *Amalungelo omhlanganyeli*: Ngingahoxa ekuhlanganyeleni kulolu cwanningo noma ngasiphi isikhathi.
17. *Ukunxeshezela ngemali*: Ngeke ngibuyiselwe imali ngenxa yokuhlanganyela kanye noma yiziphi izindleko zokuhamba.
18. *Okuyisifuba*: Ukuze kubhaleke kahle hle lokho engikushoyo ezingxoxweni, kuyosetshenziswa isiqophimazwi. Okuqoshiwe kuyolalelwa kuphela ngomphenyi omkhulu kanye namalunga agunyaziwe eqoqo labacwaningi baseNyuvesi yasePitoli, uma kudingekile.
19. Ngiyakuqondisisa ukuthi imiphumela yokuhlolwa iyogcinwa iyisifuba ngaphandle uma ngicela ukuthi ikhishwe. Imiphumela yalolu cwanningo ingasakazwa emabhukwini ongoti noma yethulwe ezingqungqutheleni zongoti, kodwa imininingwane ngami noma ubumina ngeke buvezwe ngaphandle uma kusho umthetho.
20. Uma ngineminye imibuzo noma izinkathazo, ngingashayela ucingo umcwaningi u-Monique Starkowitz kunombolo-(082) 572 8706 nganoma yisiphi isikhathi sasemini noma sasebusuku.

Ngiyawaqondisisa amalungelo ami njengomhlanganyeli wocwaningo, futhi ngivuma ngaphandle kwempopo ukuhlanganyela kulolu cwanningo, ngiyakuqondisisa ukuli lolu cwanningo lumayelana nani nokuthi lwenziwa kanjani futhi lwenziwelani. Ngizoyithola ikhophi esayiniwe yaleli fomu lwemvume

Ukusayina koMhlanganyeli

USUKU

Ukusayina koMphenyi

USUKU

Interview Schedule

Research for MSW (Health Care) degree requirements

Principal Investigator: Monique Starkowitz

Healer's Viewpoint- Depression General

What in your opinion is depression/ sadness/stress /distress? (If traditional healer does not recognise the term, the researcher will rephrase using terms sadness, distress, stress - this will obviously be reflected on in results.)

Is there a difference between depression and sadness?

What do you think causes a person to become depressed/ sad/ stressed/distressed?

Are there certain factors that cause depression?

Why would a person become depressed/ sad/ stressed/distressed?

Is depression/ sadness/ distress/stress a problem that is to do only with the patient? Or is it about other people, like the patient's family/community?

Depression as an illness

Do you think depression/ sadness/stress/ distress is an illness? What is your opinion?

Some people say that depression is a mental illness or an illness of the mind? What is your opinion?

Do you think medical doctors understand depression/sadness/ stress/ distress?

Do you think their treatment with medication is appropriate?

Spiritual Significance

What in your opinion is the spiritual significance of depression/sadness/stress/distress?

Do you think depression/ sadness/stress/ distress is a punishment?

Punishment for what?

Why spiritually will a person suffer from depression?

Diagnosis

Do you treat patients who suffer from depression?

Does a person who is depressed/stressed/ distressed need to see a traditional healer?

How can you tell if a patient is depressed/ sad/stressed/distressed?

Are there specific feelings expressed by the patient or symptoms that you look for to see if the patient is depressed/ sad/ stressed/distressed?

How would you diagnose a patient who says they are depressed/sad/stressed/distressed?

Treatment

What would your treatment entail?

Where are these people treated?

How long will you treat the patient?

Explain what is done during this treatment period?

Do they remain with their family while they are treated?

Would a person have to take any muti/medication if they are depressed/sad/stressed/distressed?

Explain what ritual will be applicable for a person who is depressed/sad/stressed/distressed? What would they have to do?

How are family involved in the treatment?

RECOMMENDATIONS

Is there anything else you want to share with me about depression/sadness/distress/

How would you want to collaborate with the medical profession?

Is there anything else you would like to share with me regarding depression?